The Bethlem Royal Hospital and the Maudsley Hospital : triennial statistical report : years 1952-1954 / edited by C.P. Blacker.

THE BETHLEM ROYAL HOSPITAL
AND THE MAUDSLEY HOSPITAL

TRIENNIAL STATISTICAL REPORT

YEARS 1952-1954

Edited by

C. P. BLACKER, M.D., F.R.C.P.

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EDITOR'S FOREWORD

This booklet is not to be taken as a conventional hospital report about medical and non-medical staff, administrative matters and finance.

The subject matter of the first five chapters is the statistical information which, as a routine, is recorded on the front page of the case-notes of every out- and in-patient. It is an essential feature of hospital policy that this front page is revised every three years. New questions replace those which have yielded desired information. A balance is thus kept between the need to maintain comparability between successive reports and the need to take cognisance of new trends in psychiatry. Flexibility is maintained and statistical archaism avoided.

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.

I am indebted to many people for help in the preparation of this report and in particular to Professor Aubrey Lewis, Dr. Michael Shepherd, Mr. K. J. Johnson, the joint hospital's house governor, and Mr. W. H. Duce. I am also indebted to Mr. A. T. Gore, co-author of the first report, and Mr. B. Benjamin, of the General Register Office.

C. P. BLACKER.

1 September 1957.

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APPENDIX

	Males	Females	Totals	
A. ADULTS			1952-54	1949-51
1. *Individual patients*				
Total	4,411	4,946	9,357	7,787
Inpatients	1,456	1,897	3,353	2,636
Outpatients	2,955	3,049	6,004	5,151
Ever-married	2,645	3,504	6,149	4,884
2. *Discharges* (sometimes multiple for the same patient)				
Total	5,586*	6,554*	12,140*	10,958*
Inpatients	1,572*	2,069*	3,641*	3,245*
Outpatients	4,014*	4,485*	8,499*†	7,713*
Ever-married	3,388	4,608	7,996	—
B. CHILDREN				
1. *Individual patients*				
Total	751	395	1,146	1,211
Inpatients	193	107	300	250
Outpatients	558	288	846	961
2. *Discharges* (sometimes multiple for the same patient)				
Total	833*	427*	1,260*	1,410*
Inpatients	200*	113*	313*	284*
Outpatients	633*	314*	947*	1,126*

* In these figures, warded outpatients are counted both as in- and outpatients.

† Bethlem Royal Hospital, 1,764 (males, 745 ; females, 1,019).

Maudsley Hospital, 1,877 (males, 827 ; females, 1,050).

Table 1. *Basic Figures. Triennium* 1952-54.

MEANING OF TERM ADMISSION

This arbitrarily defined term is used differently for in- and outpatients.

Inpatients.—A patient is counted as a new admission to a ward in the joint hospital if he has never before been so admitted. If readmitted he is also called a new admission (or readmission) however short the time that may have elapsed since his earlier discharge. (Periods of authorised leave from hospital do not count as discharges.)

Outpatients.—An outpatient is counted as a new admission to the outpatient department if he has never been so admitted before. He is also so counted if, having earlier been registered as an outpatient, he is again referred to (or spontaneously reappears in) the outpatient department after a period of *three or more months* has passed since his earlier discharge (or lapse) from that department. The term is thus defined for outpatients by what is called the *three months rule.*

In table 1 discharges and not admissions are shown because it is only when a patient is discharged that his case is closed and leaving-data (tabulated in ensuing chapters) are complete.

CHAPTER ONE

INTRODUCTION

1. The Second of Two Reports

The first of these reports, which covered the years 1949-1951, was published in 1955. The punching and sorting were done by the statistical section of the Public Health Department of the London County Council. The same services have been performed for this (second) report, which covers the triennium 1952-1954, by the Clinical Tabulating Service (Principal, John P. Mandeville). The coding and transcription were done by the same persons (Mrs. M. Perkins and Mrs. D. Cooke) for the two reports.

Six chapters of the two reports have been written by the editor, and are similarly designed in order to facilitate comparison (Chapters 1-5 and Chapter 9 of this report). Three new chapters are here included: these describe activities which have mainly developed during the years 1952-1954. Dr. Denis Leigh, who writes on domiciliary visits, has been the most active member of the joint hospital's senior staff in meeting the demands of this new service. Of the 1,421 consultations described in chapter six, he himself engaged in over nine hundred (sixty-five per cent). The day hospital, opened for women patients in 1953, was planned and has been directed by Dr. Arthur Harris, who writes chapter seven. Mr. Murray Falconer, who contributes chapter eight, is the director of a neurosurgical unit in the Maudsley's curtilage which has been administered jointly with Guy's Hospital since it was opened in 1952. His figures cover a six- and not a three-year period : they relate to the years 1951-1956.

Two Objects

These reports have two objects. The first is to record for the benefit of the hospital staff and the board of governors the activities of the hospital and to note such changes as may have internal interest. The second is to draw attention to trends in psychiatry which, though primarily typical of greater London, may also reflect events in the country as a whole, and therefore be of general interest. These trends, if discernible at all through the records system of so atypical a hospital as ours, are reflected in the figures for outpatients.

2. In- and Outpatients

All inpatients are selected for admission by a member of the joint hospital's senior staff. Two main principles are followed in the selection—that the case has teaching interest and that it is broadly remediable, however acute the illness at the time of admission. An upper limit is placed on the number of patients admissible to the hospital's wards within a triennium by the number of available beds and by the average duration of stay in hospital.

For outpatients there is no such selective principle. It is possible for any doctor practising anywhere in Great Britain to refer patients to the joint hospital, and there is no reason to doubt that the patients so referred provide a fairly representative sample of those who present psychiatric problems to the practitioners of south London. Such trends as may be noticed among outpatients are influenced, among other things, by changes in the mental habits of the community served by the hospital and in the referring habits of doctors practising in that community (Cf. chapter nine). Among these changes is an increase in what might be called psychiatric sophistication. A new attitude towards the age-old problem of mental infirmity is being vigorously fostered by the British Broadcasting Corporation, by the cinema, by the press and by American influence acting through these media. It is also percolating downwards from the relatively sophisticated upper middle class to the relatively unsophisticated lower middle and working classes (from the Registrar General's classes one and two to his classes three, four and five).

This trend might be reflected in an increase of outpatients referred to hospital for relatively minor psychiatric disturbances, in an increase of patients who ask their family doctors to refer them to a psychiatrist, and perhaps also in an increase of cases who present themselves in the outpatient department without a doctor's letter or introduction asking for treatment (spontaneous referrals: Cf. table 22).

The upper limit or ceiling to the number of outpatients with which the hospital can deal in a triennium is not as rigid as that which restricts the number of inpatients. The number of outpatient consultations which can be booked ahead is determined by the number of clinic-sessions held by consultants who see new outpatients and by the number of new patients which these consultants are prepared to see in a clinic-session. (The more that a hospital's available consultant-time is devoted to supportive treatment and to time-consuming psychotherapy, the fewer the number of new outpatients that hospital can deal with). But the joint hospital also holds an emergency clinic about which the appointments clerk is at liberty to inform a practitioner who wishes to make an appointment for a patient but who finds the waiting period long. A registrar is always available, day and night, for dealing with such emergencies. In this way, the number of outpatients received during a triennium becomes inflated over and above the calculable number for whom appointments with consultants can be booked in advance. The "ceiling" is thus less rigid than for inpatients.

But other consequences, some undesirable, follow from long waiting lists. Patients who are not really emergencies are referred to the emergency clinic. For such, the registrar commonly makes an appointment with a consultant on a relatively remote date (the waiting list being long). When the time comes the patient may fail to keep the appointment and consultant-time is wasted. A proportion

of all outpatients fail to keep booked appointments; the hospital's experience is that these failures are commoner than average among patients first seen as emergencies. Another possible consequence of an excessively long waiting list (a consequence which has been noted in at least one provincial hospital) is an increased demand for domiciliary visits.

These sequences can pass unnoticed by the consultant if he does not habitually take cognisance of the periods elapsing between the dates on which his patients' appointments were made and the dates of his consultations. It is the appointments clerk rather than the consultant who is most clearly aware of these lengthening periods, and her experience in this nexus should be continually kept in view.

3. The Two Triennia Compared

The figures for the two periods show resemblances and differences on which comments are made under the relevant tables. Among noteworthy resemblances are the percentage-distributions for diagnosis. The similarity of the figures for both inpatients (table 34) and outpatients (table 32) reflects a rather surprising consistency in the diagnostic habits of the senior staff and also in their clinical standards for admission to the hospital's wards.

Among the differences between the triennia is the balance of the sexes (sex ratios) among outpatients compared with inpatients. As shown in Table 1 (page xii) both in- and outpatients were more numerous in the second than in the first period.

Among inpatients the increase was closely similar for the two sexes: it amounted (table 2) to a little over twelve per cent for males and females, this being mainly a matter of bed accommodation. (More beds were out of commission during the first than the second period.) In both periods, moreover, there were admitted about 32 per cent more female than male inpatients—again a matter of beds.

The position was different among outpatients. Of total outpatients 10·2 per cent more were seen in the second than the first triennium (table 2); but the increase among women (14·4 per cent) was more pronounced than among men (5·8 per cent). This relative increase of female compared with male outpatients has no major administrative explanation, it being immaterial to a consultant whether he sees males or females during his outpatient sessions. But there is a minor administrative factor in the inclusion of 47 women attending the day hospital (opened in 1953) in the second triennium's total of 4,485 women. If these are omitted, the increase of 14·4 per cent of women in the second period is reduced to 13·2 per cent, and the ratio of women to men in the second period is reduced from 111·7 (table 2) to 110.1.

It looks as if the main difference in the sex ratios of the two triennia were inherent in the clinical material provided by referrals to the outpatient department. The cause of the increasing excess of

female over male outpatients is not obvious though various possibilities could be discussed. It would be interesting to know if a similar trend in the balance of the sexes had been observed at other psychiatric outpatient clinics in London over the same periods.

	Period	Males	Females	Total	Ratio females to males (males = 100)
Inpatients	1. 1949-51	1,397	1,848	3,245	132·3
	2. 1952-54	1,572	2,069	3,641	131·6
	Ratio 1:2 (1 = 100)	112·5	112·0	112·2	
Outpatients	1. 1949-51	3,794	3,919	7,713	103·3
	2. 1952-54	4,014	4,485	8,499	111·7
	Ratio 1:2 (1 = 100)	105·8	114·4	110·2	

Table 2. Admissions compared of males and females during the two triennia to the wards and to the outpatients' department.

4. Diagnostic Lists: Individuals and Discharges

As in the first of these reports, a nineteen point list—a condensation of section V of the international classification shown in an appendix—has been used in chapter four. Both classification and list are open to criticisms some of which were advanced in the first report (pp. 6-12).

Of the chapters which follow, the second deals with individuals, and the third and fourth with discharges, sometimes multiple for the same individual. Chapter five, concerned with children, deals with both. Though figures for discharges involve some duplication of individuals (because of multiple admission of some individuals during the triennium) all the features dealt with in chapter three vary with each admission.

There are, in fact, four ways in which total figures can be presented in a report of this kind which covers multiple admissions and discharges of the same individual over a specified time-period, and which also deals with both in- and outpatients:

(*a*) Total *discharges* of inpatients plus total *discharges* of outpatients. These number 12,140 during the triennium.

(*b*) Total *discharges* of inpatients plus total *discharges* of outpatients from which are subtracted those which related to inpatients who pass through the outpatient department on their way into and out of the wards. The figure has not been compiled for the second triennium. For the first it was 8,725.

(*c*) Total number of *individuals* discharged (once or more often) from the wards plus the total number of *individuals* discharged (once or more often) from the outpatient department. The figure has not been compiled for the second triennium.

(*d*) Total number of *individuals* dealt with once or more often either as in- or outpatients. These number 9,357 in the triennium.

5. Pathological and Immature Personalities

Every country has its quota of these people who may present intractable social and eugenic problems. They have recently been given prominence by the *Royal Commission relating to Mental Illness and Deficiency* (1957) and they will increasingly perplex the country's mental health services. They will certainly attract more notice than heretofore. Hence a summary of the findings over the triennium may be of interest. It is as follows: patients with pathological and immature personalities, treated as a diagnostic group, are young, the average age of men being 31·9 and of women 31·1 (table 40); over half are single—55 per cent of men and 51 per cent of women (table 41); when they marry, their marriages are apt to be unstable, a substantial fraction of the hospital's sample (21·6 per cent of men and 28·7 per cent of women: table 43) having ended in divorce or separation; but while their marriages last, they are apt to be fertile (table 47).

6. *Changes in Staff.*

Table 2*a* shows changes in staff between 1949 and 1954.

	1949		1954	
	Whole-time	Part-time	Whole-time	Part-time
Doctors				
Senior Staff	10	8	8*	14†
Junior Staff	44		60	
Nurses	182	49	247	84
Psychologists	6		10	
P.S.W's	11		11	
Occupational Therapists...	9		12	

Table 2a. Joint Hospital's professional staff: numbers in 1954 compared with 1949 (extra mural activities included):—

1954 Senior Staff :—

Full-time* :	7 Psychiatrists	1 Pathologist
Part-time† :	11 Psychiatrists	1 Dental Surgeon
	1 Radiologist	1 Neurosurgeon

CHAPTER TWO

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

1. Basic Figures

At the beginning of chapter one are set out (table 1) the basic figures which recur in the ensuing tables. As mentioned on page 4, all the figures given in this second chapter relate to the number of *individuals* covered during the triennium, of whom there were 9,357. Patients admitted and discharged more than once during the period are counted once only.

2. Age of Patients

The age-distribution is shown in table 3. It will be seen that females (40·1 years) are on average two years older than males (38·1 years). For the first triennium there was a difference of two and a half years (females 39·2, males 36·7 years).

The age-group 25-34 is the best represented of the six. It is during these years that the stresses of marriage and child-bearing are mostly felt. Of female patients 65 per cent are of reproductive age, being under forty-four—a distribution which influences estimates of total fertility.

The percentage figures for the two triennia are closely similar for the three age-groups covering the ages 25-54. But the second period's patients were on average about a year and a quarter older than the first's: a difference of 2.4 per cent in the youngest age-group is balanced by corresponding differences in the two oldest.

Age is related to diagnosis in respect of *discharges* (not individuals) in table 40 below.

Age group	Males		Females		Total		
	No.	%	No.	%	No.	%	% 1949-51
16-24 years ...	701	15·9	697	14·1	1,398	15·0	17·4
25-34 years ...	1,407	31·9	1,391	28·1	2,798	29·9	29·8
35-44 years ...	1,014	23·0	1,145	23·2	2,159	23·1	23·2
45-54 years ...	670	15·2	802	16·2	1,472	15·7	15·6
55-64 years ...	389	8·8	538	10·9	927	9·9	9·1
65-	229	5·2	372	7·5	601	6·4	4·9
Age not known	1		1		2		
Totals ...	4,411	100·0	4,946	100·0	9,357	100·0	100·0
Average age	38·1		40·1		39·2		37·9

Table 3. *Age of hospital population.* 9,357 *in- and outpatients.*

3. Marital Status

Table 4 shows a four-point distribution of 9,357 in- and out-patients. It will be seen that males proportionally outnumber females by more than ten per cent in the first category of single (never-married) patients, but that females are better represented in the other three groups. As is to be expected, the difference is most pronounced among the widowed (2·4 per cent males against 8·4 per cent females).

The percentages of single patients compared with those for the first triennium and for the population of greater London show differences between the sexes. There were fewer single (34 compared with 37.2 per cent) and more married patients (54.3 compared with 51.0 per cent) in the second than in the first period (table 4). The figure of 39.7 per cent for single males is closely similar to that of 40.3 per cent for the first triennium. Both these figures are conspicuously higher than the equivalent figure of 25·1 per cent for the population of greater London given by the 1951 census (see table 4, first triennial report). But the figure of 29·0 per cent of single females is appreciably smaller than that of 34.1 per cent for the first triennium and it is close to the equivalent figure for the population of greater London (28.0 per cent). A comparison of the age distribution of single women in the two triennia (table 5 and table 4 of the first report) shows that the difference mainly relates to the younger age-groups: relatively fewer young female patients were single in the second compared with the first period (69·5 compared with 78·8 per cent in the 16-24 age-group). Indeed there were relatively fewer single women-patients in the second compared with the first period in all the age-groups except the oldest aged 65 and over.

The relative excess of single males over females is discussed in terms of diagnosis on page 53 (table 41). It is there shown that the difference is most pronounced in the large groups (comprising between them over 2,800 patients) of schizophrenics and anxiety cases. Why relatively fewer female patients were unmarried in the second compared with the first triennium, is not obvious. The fact that the difference is most pronounced in the youngest age-group suggests as a possible factor the numerical equalisation between the sexes which is progressively attained as the generation that was too young to suffer male casualties in the war reaches marriageable age.

Table 5 shows a distribution by age of three categories of patients, namely the single, the divorced and separated (whose marriages have been terminated otherwise than by death) and a third group called "other" which here comprises both the married and widowed. (Of 38 patients the relevant particulars were not known.)

It will be seen from the totals section (at the bottom of the table) that the proportion of single decreased with advancing age from a figure of 80 per cent among those aged 16-24 to one of 16 per cent among those of sixty-five and over. The decline with age in the

proportion of single is smoother among males than females among whom there is an irregularity in the age-group 45-54 wherein the proportion of single (22.4 per cent) is higher than among women ten years younger (20.3 per cent). Male casualties in the 1914-18 war may have a bearing. Marriages broken by divorce or separation occur rather more frequently among late middle-aged than old patients, the highest figure (9·6 per cent) being that for males aged 45-54.

Table 6 is based on ever-married patients and provides a better guide to the outcome of marriage than do tables 4 and 5, which are based on total patients. It will be seen that 9·2 per cent of the recorded marriages ended in divorce or separation, the rate for men being slightly higher than for women. This figure compares favourably with that of 11·3 per cent for the earlier triennium.

The figures for marriages broken by death show opposite differences. Many more women than men are widowed (11·8 against 3·9 per cent), and widowed patients were better represented in the second triennium (8·4 per cent) than the first (7·5 per cent).

Table 7 shows that the percentage of ever-married patients who have been married more than once is the same (7·1 per cent) in the two triennia, but that in the second (unlike the first) relatively more men than women had married more than once.

Marital status	Males		Females		Total		
	No.	%	No.	%	No.	Per cent	
						'52-54	'49-51
Single	1,742	39·7	1,428	29·0	3,170	34·0	37·2
Divorced or Separated ...	254	5·8	312	6·3	566	6·1	7·1
Widowed ...	104	2·4	414	8·4	518	5·6	4·7
Married ...	2,287	52·1	2,778	56·3	5,065	54·3	51·0
Total known ...	4,387	100·0	4,932	100·0	9,319	100·0	100·0
Status not known	24		14		38		
Total	4,411		4,946		9,357		

Table 4. *Marital status by sex.*

9,357 in- and outpatients.

Age-Group (years)	Total	Single		Div. or Sep.		Other		
		No.	%	No.	%	No.	%	
Males								
16-24 ...	700	633	90·4	5	·7	62	8·9	100·0
25-34 ...	1,401	683	48·8	74	5·3	644	45·9	100·0
35-44 ...	1,009	257	25·5	73	7·2	679	67·3	100·0
45-54 ...	664	102	15·4	64	9·6	498	75·0	100·0
55-64 ...	385	42	10·9	29	7·5	314	81·6	100·0
65+ ...	228	25	11·0	9	3·9	194	85·1	100·0
Total	4,387	1,742	39·7	254	5·8	2,391	54·5	100·0
Females								
16-24 ...	696	484	69·5	13	1·9	199	28·6	100·0
25-34 ...	1,389	367	26·4	93	6·7	929	66·9	100·0
35-44 ...	1,144	232	20·3	95	8·3	817	71·4	100·0
45-54 ...	798	179	22·4	66	8·3	553	69·3	100·0
55-64 ...	534	95	17·8	39	7·3	400	74·9	100·0
65+ ...	371	71	19·2	6	1·6	294	79·2	100·0
Total	4,932	1,428	29·0	312	6·3	3,192	64·7	100·0
Totals								
16-24 ...	1,396	1,117	80·0	18	1·3	261	18·7	100·0
25-34 ...	2,790	1,050	37·6	167	6·0	1,573	56·4	100·0
35-44 ...	2,153	489	22·7	168	7·8	1,496	69·5	100·0
45-54 ...	1,462	281	19·2	130	8·9	1,051	71·9	100·0
55-64 ...	919	137	14·9	68	7·4	714	77·7	100·0
65+ ...	599	96	16·0	15	2·5	488	81·5	100·0
Total	9,319	3,170	34·0	566	6·1	5,583	59·9	100·0

Table 5. Marital status by age and sex.

9,319 in- and outpatients.

Outcome of marriage	Males (2645)		Females (3504)		Total (6149)		
	No.	%	No.	%	No.	Per cent	
						1952-54	1949-51
Marriage broken by:							
Death	104	3·9	414	11·8	518	8·4	7·5
Divorce or separation	254	9·6	312	8·9	566	9·2	11·3

Table 6. Marital status by sex.

Broken marriages. Two triennia compared. 6,149 ever-married in- and outpatients.

	Ever-married patients	No. married more than once		
		Number	Per cent	
			1952-54	1949-51
Males ...	2,645	211	8·0	6·7
Females ...	3,504	227	6·5	7·5
Total ...	6,149	438	7·1	7·1

Table 7. Marital status.

Patients married more than once. 6,149 ever-married in- and outpatients.

4. Religion

Table 8 shows that the distribution is generally similar to that for the first triennium. A little under three quarters belong to the Church of England, 11·6 per cent are Roman Catholics, 6·5 per cent Non-conformists and 3·7 per cent Jews. Between the sexes, the most pronounced difference is in respect of those who declare that they have no religion, among whom, though numbers are small, males are more than twice as numerous as females (135 compared with 62). There is less difference between the distributions among adults and children (c.f. table 68) than in the earlier period when, among the parents of children, there were relatively more members of the Church of England and fewer non-conformists than among adult patients (c.f. tables 9 and 64 of the first report).

Religion	Males		Females		Total		
	No.	%	No.	%	No.	Per cent	
						1952-54	1949-51
Church of England	3,137	72·3	3,624	74·4	6,761	73·5	74·1
Roman Catholic	516	11·9	550	11·3	1,066	11·6	11·3
Non-Conformist	267	6·2	335	6·9	602	6·5	6·4
Jewish	152	3·5	188	3·8	340	3·7	4·4
Other	129	3·0	111	2·3	240	2·6	3·8
None	135	3·1	62	1·3	197	2·1	
Total known ...	4,336	100·0	4,870	100·0	9,206	100·0	100·0
Not known ...	75	—	76	—	151	—	—
Total patients ...	4,411	—	4,946	—	9,357	—	7,787

Table 8. Religious affiliations by sex.

9,357 in- and outpatients.

5. Age at First Marriage

Table 9 shows that the distribution for the two triennia is fairly similar. There were 4,884 ever-married patients in the first and 6,149 in the second period. Patients of both sexes seen in the second period married somewhat earlier than those seen in the first—males about six months and females about ten months earlier. Sixty-three per cent of females and 41 per cent of males had married before the age of 24.

Age at first marriage	Males			Females		
	No.	Per cent		No.	Per cent	
		'52-'54	'49-'51		'52-'54	'49-'51
Under 20	90	3·6	3·1	507	15·3	15·1
20–24	949	37·7	39·4	1,602	48·2	47·7
25–29	905	36·0	35·8	839	25·3	25·6
30–34	351	13·9	13·4	227	6·8	7·4
35–39	152	6·0	5·6	90	2·7	2·5
40–45	49	1·9	1·9	33	1·0	1·0
45+	22	0·9	0·8	23	0·7	0·7
Total marriage age known	2,518	100·0	100·0	3,321	100·0	100·0
Age not known ...	127	—	—	183	—	—
Married patients total ...	2,645	—	—	3,504	—	—
Average age at marriage	—	26·5	27·0	—	24·0	24·8

Table 9. *Age at first marriage by sex.*

6,149 ever-married in- and outpatients.

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

Table 10 shows the distribution, and should be considered with tables 12 and 12a of the first of the reports. The figures for patients were there compared with those for the general population according to the probable date of their parents' marriage. (Though the families of the great majority of the parents of our patients are complete, though, in other words, it is unlikely that our patients will have more brothers and sisters by their own mothers, the size of their sibships will vary with how long ago their parents were married. Families were large in Victorian days and their size has steadily declined from about 1875 to 1933). The figures shown in table 12a of the first triennial report did not suggest that the family sizes of our patients differed much from the national averages.

Nor do the figures for the second triennium. It will be seen from table 10 that these, after correction by the Greenwood-Yule formula (explained on page 22 of the first report), are compared with the similarly corrected figures for the first triennium. The differences, which are small, are in the direction of the sizes of sibships in the later period being smaller than in the earlier. Thus in respect of males the corrected figures for two age-groups (the second and third), are the same for the two triennia, while in the other four age-groups, they are smaller for the second than the first; the difference is most pronounced in the oldest age-group (the family size for males over 65 having averaged 4.2 in the second period and 4.8 in the first). For female patients, the family sizes for the second triennium are appreciably smaller than those for the first in respect of the two oldest age-groups which together comprise women of 55 and over. On the other hand, women aged 45-54 form the only group wherein the corrected size of sibship for the second period was higher than for the first.

The relevant information as to size of sibship was not obtained or was unknown of 6.3 per cent of patients (607 among 9,357), a history of illegitimacy and of consequent nescience as to sibs not being uncommon.

How would the size of a patient's sibship react on his mental health? Obviously an only child is more likely to be spoiled and over-protected than a child occupying a middle or late place in a large family. On the other hand, a late-born and misconceived child in a large "problem" family is likely to suffer from neglect. In later life these two groups will experience different inner stresses and, if brought into contact with psychiatrists, will present different pictures. But it is as yet uncertain how far these differences, real though they be, can be distinguished and differentiated in terms of the necessarily crude categories of the international classification here used.

Clearly birth order (whether the patient is a first, second or sixth child) is here scarcely less important than the size of his sibship. It is hoped to deal with birth order more fully in the report for 1958-60.

Size of sibship is further discussed in terms of diagnosis, on pages 57-58 below (table 44).

Age-group (years)	Males				Females			
	Nos.	Sibship recorded size	Sibship corrected size		Nos.	Sibship recorded size	Sibship corrected size	
			52–54	49–51			52–54	49–51
16–24 ...	662	3·5	2·3	2·4	660	3·6	2·3	2·4
25–34 ...	1,324	4·2	2·8	2·8	1,320	4·4	2·8	2·9
35–44 ...	947	4·9	3·2	3·2	1,079	4·9	3·3	3·3
45–54 ...	621	5·2	3·5	3·6	753	5·6	3·8	3·7
55–64 ...	357	5·6	4·0	4·1	495	5·7	4·0	4·6
65+ ...	206	6·0	4·2	4·8	326	6·2	4·4	4·9
Total ...	4,117				4,633			
Not known	294				313			
Total ...	4,411				4,946			

Table 10. *Size of patients' sibships (including the patient) by sex and age.*

9,357 in- and outpatients.

7. Fertility

Reasons were given in the first of these reports for supposing that the fertility of hospital patients admitted between 1949 and 1951 was below the national average. There was little difference in respect of patients under 34; but among patients above that age fertility was probably less than the average for Great Britain.

Table 12 shows that the position is little changed in the second triennium. It will be seen that the average number of children of ever-married females is the same in the two periods (1·68 children); but that among males, the figure for the second period (1·76) is higher than for the first (1·71).

The figure for both sexes is thus slightly higher for the second than for the first period (1·72 compared with 1·69). Table 12, which gives a distribution of patients by the number of their children, suggests that the difference is mainly due to a relative increase in three-child families. The difference of 1·1 between the percentages of three-child families in the two triennia is more than twice the corresponding difference between families of any other size.

Fertility is related to diagnosis in table 47.

Age group	Males		Females		Totals		
	No.	Av. child.	No.	Av. child.	No.	Average children 1952-54	1949-51
16–24 ...	66	0·65	211	0·70	277	0·69	0·67
25–34 ...	707	1·29	1,018	1·42	1,725	1·36	1·31
35–44 ...	742	1·81	896	1·67	1,638	1·74	1·65
45–54 ...	544	1·90	609	1·69	1,153	1·79	2·10
55–64 ...	337	2·13	432	1·88	769	1·99	2·35
65+ ...	199	2·61	285	3·11	484	2·90	2·70
Total ...	2,595	1·76	3,451	1·68	6,046	1·72	1·69
Not known	50		53		103		
Total ...	2,645		3,504		6,149		

Table 11. *Fertility by sex and age.*

Average number of children born alive by age of parents.
6,149 ever-married in- and outpatients.

Number of children	Males		Females		Totals		
	No.	%	No.	%	No.	Per cent 52-54	49-51
None ...	637	24·5	812	23·5	1,449	24·0	24·3
One	709	27·3	1,024	29·7	1,733	28·7	29·2
Two	615	23·7	861	24·9	1,476	24·4	24·8
Three	318	12·3	397	11·5	715	11·8	10·7
Four	147	5·7	168	4·9	315	5·2	4·9
Five-six ...	110	4·2	128	3·7	238	3·9	4·0
Seven-nine ...	47	1·8	45	1·3	92	1·5	1·6
Ten+ ...	12	·5	16	·5	28	·5	0·5
Total known	2,595	100·0	3,451	100·0	6,046	100·0	100·0
Not known ...	50		53		103		
Total ...	2,645		3,504		6,149		
Average number of children	1949-51	1·71		1·68		1·69	
	1952-54	1·76		1·68		1·72	

Table 12. *Fertility. Distribution of family size (number of children born alive) by sex.*

6,149 ever-married in- and outpatients.

8. Social Class

The distribution shown in table 13 does not discriminate between in- and outpatients as does table 15 of the first of these reports. For reasons there given the relevant information is more difficult to obtain from women than men: of 650 women (13·1 per cent) and 150 men (3·4 per cent) it was not obtained. Social class is determined by employment of which table 15 shows the distribution: it will be seen that 8 per cent of women compared with 2·2 per cent of men were not occupationally classified.

As in the first triennium, the distribution of women is more median than of men: there are relatively fewer women than men in classes one and five, and relatively more in classes two, three and four. The different distributions might be due to several causes: they might, for example, be due to a more pronounced tendency for ever-married women (71 per cent of the total of women patients: Cf. table 4) of classes two, three and four to suffer in mental health than their husbands; or they might be due to fewer unmarried female than male patients being assignable to classes one or five. This matter will be examined in a further report.

There is little difference between the distributions in the two triennia—much less than in those of gross income (Cf. table 14). The large class three (middle class) is a little less well represented in the second period than in the first (55·4 compared with 58·4 per cent).

Social class		One	Two	Three	Four	Five	Total known	Not known	Total
Males	Nos.	242	623	2,254	480	662	4,261	150	4,411
	Per cent	5·7	14·6	52·9	11·3	15·5	100·0	3·4	
Females	Nos.	142	677	2,486	715	276	4,296	650	4,946
	Per cent	3·3	15·8	57·9	16·6	6·4	100·0	13·1	
Totals	Nos.	384	1,300	4,740	1,195	938	8,557	800	9,357
	Per cent								
	'52-'54	4·5	15·2	55·4	14·0	10·9	100·0	8·5	
	'49-'51	4·5	13·3	58·4	13·0	10·8	100·0	6·9	
Greater London Males only (1946)		4·9	16·6	54·7	10·7	13·1	100·0		

Table 13. *Social Class by sex.*

9,357 in- and outpatients.

9. Usual Weekly Income

It will be seen from table 14 that, of 9,357 patients, the relevant information was not available for a little over a quarter (27·3 per cent)—an improvement of seven per cent on the earlier triennium. Of the remaining 6,800 patients 44·9 per cent had a gross income of between £7 and £12 a week.

As in the first triennium, in-patients of both sexes are better represented than outpatients in the highest income bracket of over £12 a week.

Rather surprisingly (in view of the more median distribution of women than men in respect of social class) the distribution here is more median in respect of men than women. There are slightly fewer men than women in the highest recorded bracket (over £12 a week: 17·5 per cent of men compared with 18·7 per cent of women), and appreciably fewer in the lowest bracket (under £4: 6·7 of men compared with 11·6 per cent of women). This more median distribution of men than women reproduces the findings of the first triennium when the percentages, in the top bracket, were respectively 8·1 and 7·1 for women and men and, in the bottom bracket, respectively 18·9 and 9 per cent.

That women outnumber men in the lowest bracket may partly reflect a circumstance which would mainly affect the young and unmarried, namely that women's wages are apt to be lower than men's, and the better representation of women in the top bracket may again be due to the unequal incidence of single (never married) persons between the sexes. More males than females were single (Cf. tables 4 and 5). The total gross income as shown in table 14 includes the earnings of both sexes. Hence more females than males would benefit from the earnings of a spouse.

But the most conspicuous feature of table 14 is the comparison between the two triennia. Incomes have conspicuously risen. In the second, 63 per cent of patients had incomes of over £7 a week (two top brackets); in the first the figure was 35·8 per cent. In the first period, over half (50·4 per cent) the patients had incomes of from £4-£7 a week; in the second little more than a quarter (27.7 per cent). These changes reflect general trends. I am indebted to Mr. A. T. Gore for pointing out that, between 1950 and 1953 (the mid years of the reports) the wage rates of males rose by 22 per cent and of females by 23 per cent.

		Usual weekly income (gross)										Not known		Total
		Over £12		£7–12		£4–7		Under £4		Total known				
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Males														
Inpatients		222	22·2	412	41·3	294	29·4	71	7·1	999	100·0	457	31·4	1,456
Outpatients		349	15·4	1,159	51·1	614	27·0	148	6·5	227,0	100·0	685	23·2	2,955
Total males		571	17·5	1,571	48·0	908	27·8	219	6·7	3,269	100·0	1,142	25·9	4,411
Females														
Inpatients		243	20·9	446	38·4	317	27·3	155	13·4	1,161	100·0	736	38·8	1,897
Outpatients		418	17·6	1,035	43·7	662	27·9	255	10·8	2,370	100·0	679	22·3	3,049
Total females		661	18·7	1,481	42·0	979	27·7	410	11·6	3,531	100·0	1,415	28·6	4,946
Total: both sexes	1952–54...	1,232	18·1	3,052	44·9	1,887	27·7	629	9·3	6,800	100·0	2,557	27·3	9,357
	1949–51...	389	7·6	1,444	28·2	2,580	50·4	706	13·8	5,119	100·0	2,668	34·3	7,787

Table 14. *Usual weekly income* (*gross*). *Distribution by sex and in- or outpatient status.*

9,357 in- and outpatients.

10. Occupation

The distribution of 9,357 in- and outpatients is given on table 15 where the percentages are compared with those for the earlier triennium. In the earlier report, the figures were compared with those for Greater London, and it was remarked that the occupational distribution of patients corresponded fairly closely except in respect of the larger representation of patients in clerical occupations (code-numbers 890-895 of 1951 census).

The distribution for the triennium 1952-54 is generally similar to the earlier one. If both sexes are taken together, clerks, typists, etc. (code numbers 890-895), who aggregate 1408, easily take first place. As a bad second (mustering little more than half the number of clerks and typists), come 757 patients in professional and technical occupations (codes 760-819). Among males other well-represented occupations, comprising over 10 per cent of the total, are engineering, etc. (11 per cent: codes 110-279: representation in Greater London in 1951 13·0 per cent); transport and communication (10·7 per cent: codes 630-709: representation in Greater London in 1951 11 per cent), and unskilled occupations (10·6 per cent: codes 930-979: representation in Greater London in 1951 14·2 per cent).

If the two triennia are compared it will be seen that the distributions are rather similar, there being but three groups in which the difference exceeds one per cent.

Easily the most conspicuous of these differences is provided by the group of unskilled occupations (codes 930-979) where, among males, the proportion in the second period (10·6 per cent) is more than six per cent lower than in the first (16·8 per cent: incidence in Greater London in 1951, 14·2). (In this group were also one per cent fewer females.) The second largest difference is provided by an increase of males in the large assortment of professional and technical occupations (codes 760-819) from seven per cent in the first triennium to ten per cent in the second. The third group in which the inter-triennial difference exceeds one per cent is that of housewives which were rather better represented in the second than in the first period (42·2 compared with 40·9 per cent).

It will be seen from the footnote to the caption of table 15 that, in the first triennium, students were included in the group designated as "retired or not gainfully employed". The aggregate figures for these two groups in the second period are almost exactly the same as those for the first.

It is probable that the figure of 3·3 per cent for married women engaged in part time work is too small. Women are still reluctant to acknowledge that they as well as their husbands contribute to the household exchequer.

Occupation Code No.	Occupations abbreviated and grouped	Males		Females		1949–51 Males	1949–51 Females
		No.	%	No.	%	3,857	3,930
010–030	Agriculture	63	1·4	8	0·2	1·6	0·2
040–059	Mining and quarrying	1	0·0	—	—	—	—
060–089	Non-metal mining products (excluding coal)	7	0·0	3	0·1	—	—
090–109	Coal, gas, chemical and allied trades	6	0·1	—	—	—	—
110–279	Metal manufacturing, engineering, etc.	487	11·0	17	0·3	11·1	0·6
280–349	Textile workers	3	0·1	5	0·1	1·0	2·4
380–419	Textile workers	51	1·2	119	2·4		
350–379	Tanners, leather, fur dressing	17	0·4	7	0·2	—	—
420–469	Food, drink and tobacco	28	0·6	4	0·1	—	—
470–489	Wood, cane and cork	86	2·0	—	—	1·9	—
500–539	Paper board printing	87	2·0	16	0·3	1·6	0·3
540–579	Other products	9	0·2	3	0·1	—	—
580–599	Building	174	3·9	2	0·0	4·2	—
600–609	Painters and decorators	113	2·6	2	0·0	2·8	—
610–629	Administrators and managers	110	2·5	7	0·2	3·0	0·3
630–709	Transport and communications	470	10·7	69	1·4	10·4	1·4
710–759	Commercial (excluding clerical), finance and insurance	402	9·1	194	3·9	9·3	3·9
760–819	Professional and technical (excluding clerical)	441	10·0	316	6·4	7·0	5·6
820–839	Defence services (including police)	67	1·5	3	0·1	—	—
840–855	Entertainment and sport	55	1·2	19	0·4	—	—
861–888	Personal service (domestic, waiters)	251	5·7	472	9·5	5·3	10·4
890–895	Clerks, typists, etc.	646	14·6	762	15·4	14·8	15·8
900–909	Warehouseman, storekeepers, packers, bottlers	124	2·8	50	1·0	2·6	1·3
910–921	Stationary engine drivers, tractor drivers, stokers, etc.	35	0·8	2	0·0	—	—
930–979	Unskilled and other undefined occupations	467	10·6	160	3·2	16·8	4·2
980	Educational students	107	2·4	58	1·2	*	*
	Total occupied	4,307	97·6	2,298	46·5	93·4	46·4
	Retired or not gainfully employed	7	0·2	1	0·0	*2·6	*1·4
	Unemployed (other usual occupation not specified)	97	2·2	396	8·0	3·0	1·0
	Occupation not stated					1·0	8·8
	Housewives	—	—	2,086	42·2	—	40·9
	Married women engaged in part-time work	—	—	165	3·3	—	1·5
	Total	4,411	100·0	4,946	100·0	100·0	100·0

Table 15. *Principal occupations by sex.*

9,357 in- and outpatients combined. Code numbers are those of the 1951 census.

* In the first triennial report, students (Code 980) were classified with "retired or not gainfully employed persons".

11. Off-work Period or Unemployment

As shown in table 16, the employment status was known of 6,056 out of 9,357 patients—a 65 per cent sample. Women largely exceed men in the total of 3,301 "not known" cases because housewives not gainfully employed are here included. (Table 15 shows that forty-two per cent of women in the sample were recorded as housewives.)

Of the 6,056 "known" cases, 2,892 or 47·8 per cent were on admission recorded as off work or unemployed. More women than men were so placed—51·4 compared with 45·7 per cent.

Table 17 shows, in three broad groupings, the duration of the period during which, before admission, patients had been off work. The percentages are fairly closely similar for the two sexes. Forty-two per cent had been away from work for under a month, 38 per cent for 1-12 months, and a fifth (twenty per cent) for over a year. The distribution is much the same for the two triennia.

	Total	Employment status					
		Not known	Known	At work		Not at work	
				No.	%	No.	%
Males ...	4,411	512	3,899	2,116	54·3	1,783	45·7
Females	4,946	2,789	2,157	1,048	48·6	1,109	51·4
Total ...	9,357	3,301	6,056	3,164	52·2	2,892	47·8

Table 16. *Off-work period or unemployment before admission.*

9,357 in- and outpatients.

	Period off work or unemployed						Total	
	Under month		1–12 months		Over a year			
	No.	%	No.	%	No.	%	No.	%
Males... ...	750	42·1	665	37·3	368	20·6	1,783	100·0
Females ...	464	41·8	433	39·1	212	19·1	1,109	100·0
Total 1952–54	1,214	42·0	1,098	38·0	580	20·0	2,892	100·0
Total 1949–51	1,015	39·3	1,070	41·4	500	19·3	2,585	100·0

Table 17. *Off-work period or unemployment before admission.*

Duration among 2,892 in- and outpatients.

CHAPTER THREE

THE PATIENT AND THE HOSPITAL

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

These contacts are taken in chronological order. Events connected with admission are followed by those relating to stay in hospital (of inpatients) and to number of attendances (of outpatients); lastly are considered the conditions and circumstances of discharge.

Only one of the tables (table 27: Outcome of Treatment, page 33) is based on assessments; the rest are compiled from objectively verifiable information.

The tables in chapter two are based on *individuals*. Those in this chapter and in chapter four, which is concerned with diagnosis, are based on *discharges* (numbering 12,120) which may be multiple for the same individual during a triennial period (see table 1). A classification by discharges rather than by admissions is necessary when dealing with investigations, treatments, outcome of treatments, disposals and other events considered in this chapter, which are not completed until the patient is discharged.

1. Previous Admissions

(*a*) *Inpatients*

The Joint Hospital's convention is to treat as an admission to the ward (inpatient admission) every patient so admitted either for the first time or (if a readmission) irrespective of the time that has elapsed since his previous admission. The convention differs from that which is followed for outpatients (see below).

It will be seen from table 18 that:

(1) 17·6 per cent of inpatients had been inpatients before.

(2) Slightly more females than males had previously been admitted—18·6 against 16·4 per cent.

(3) The figures for the triennium are closely similar to those for 1951—the last year of the earlier triennium.

Previous admissions are related to diagnosis in table 49 below.

		Total patients		None	1	2	3	4+	
Males ...		1,572		83·6	11·8	3·2	0·6	0·8	100
Females ...		2,069		81·4	13·0	3·8	1·4	0·4	100
Total	1952–54	3,641	No.	2,998	455	129	39	20	
			%	82·4	12·5	3·5	1·1	0·5	100
	1951 only	1,226		83·9	12·6	2·6	0·7	0·2	100

Table 18. *Previous admissions at any time of inpatients to the adult wards as inpatients.*

3,641 inpatient discharges.

(b) Outpatients

An "admission" to the outpatients' department should be distinguished from the number of attendances, or times seen by a doctor, in the course of each admission (Cf. section 5 of this chapter).

The joint hospital's convention is to treat as a new admission (or readmission) to the outpatient department any adult patient who has not attended the hospital before or who, if readmitted, has not attended for a period of *three months* and with whom no appointment has been made to attend on a date more than three months ahead. (Not included as new admissions are those for whom an appointment has been made, however far ahead, as part of a follow-up or supportive régime). Our definition of a new admission or reception to the outpatient department thus turns on what we call the "three months' rule".

Table 19 gives the distribution of 8,492 (out of 8,499) outpatient discharges of whom relevant information was recorded ("known" cases).

It will be seen from a comparison of tables 18 and 19 that re-admissions to the outpatient department are proportionately more numerous than re-admissions to the wards—32·1 against 17·6 per cent. This difference is in accordance with expectation. The hospital is under no obligation to re-admit inpatients to the wards and these are not usually re-admitted unless they are of teaching interest or unless the patient would specially benefit from readmission. Chronic or intractable cases are commonly referred as voluntary patients to

mental hospitals. Outpatients, on the other hand, are always received again in the outpatient department if they ask for an appointment or if the patient's doctor asks for one.

It will be seen that females are readmitted slightly more often than males (33·6 against 30·4 per cent) and that about a third (32·1 per cent) of all admissions to the outpatient department are readmissions.

	Total patients	Known	Previous admissions to outpatients' dept.							Total
			None	1	2	3	4	5	6+	
Males	4,014	4,009	69·6	19·7	6·9	2·4	0·9	0·3	0·2	100
Females ...	4,485	4,483	66·4	22·4	7·4	2·4	1·0	0·2	0·2	100
Total	8,499	8,492	67·9	21·1	7·2	2·4	0·9	0·3	0·2	100

Table 19. *Previous admission at any time of outpatients to outpatient department.*

8,499 outpatient discharges.

2. Relatives Treated at the Joint Hospital

Of 476 (3·9 per cent) of the 12,140 discharged patients, it was not known whether or not their relatives had been treated at the joint hospital. Among these were illegitimate or adopted persons who knew nothing of their kin-folk. It will be seen from table 20 that 7 per cent of the remainder had relatives who had been treated at the Joint Hospital. The proportion is closely similar to that for the earlier triennium (6·8 per cent) and again the figure is slightly larger for women than for men.

Sex	Totals	Not known	Known	Relatives not treated		Relatives treated	
				No.	%	No.	%
Males ...	5,586	248	5,338	5,011	93·9	327	6·1
Females ...	6,554	228	6,326	5,831	92·2	495	7·8
Totals ...	12,140	476	11,664	10,842	93·0	822	7·0
1949–51 ...	8,725	332	8,393	7,819	93·2	574	6·8

Table 20. *Relatives previously treated at the joint hospital.*

12,140 in and outpatient discharges.

3. Referring Agencies

In and outpatients are separately considered. Referrals may be multiple for inpatients—for example a patient referred by an outside agency is commonly first seen in the hospital's outpatient department; the agency and the outpatient department are then recorded as sources of an inpatient's referral.

Inpatients. Table 21 shows that, allowing for multiple referrals, 3,641 discharged inpatients had been the subject of 5,053 referrals.

It will be seen that, apart from general practitioners and the joint hospital's own outpatient department, the referring agencies are tabulated in a descending order of the totals columns. Nearly a fifth (19·8 per cent) of the discharged patients came from observation wards. (The observation ward of St. Francis's Hospital is staffed by members of the Joint Hospital's medical staff.) It will further be seen that a tenth (10·5 per cent) of the total came from the psychiatric units or departments of general hospitals few of which have beds on the same scale as the joint hospital (per year an average of over 125 patients from this source were admitted to the wards); and that a twelfth (8·2 per cent; an average of 100 a year) of discharged patients had been admitted as a result of domiciliary visits paid by members of the Joint Hospital's consulting staff. It will also be seen from a comparison of the figures for the two triennia that, with the exception of item six (consulting psychiatrists outside the joint hospital); the proportions of total discharges shown in the first ten categories were higher in the later than in the earlier triennium. In respect of items 2 and 4 (psychiatric units or psychiatric departments of general hospitals and corresponding non-psychiatric departments of such hospitals) the figures are double or more than double those of the earlier period. An increasing use was thus made of the Joint Hospital's in-patient facilities by outside agencies.

Between the sexes there are no conspicuous differences. In this respect inpatients differ from outpatients (see below).

Referring agent	Males		Females		Totals		Totals 49-51
	No.	%	No.	%	No.	%	%
1. Observation ward	338	21·5	384	18·6	722	19·8	13·9
2. Psychiatric unit or department of general hospital	160	10·2	223	10·8	383	10·5	5·3
3. B/M domiciliary service	77	4·9	223	10·8	300	8·2	5·2
4. Non-psychiatric hospital or department	82	5·2	129	6·2	211	5·8	2·3
5. Consultant psychiatrist on B/M staff	82	5·2	99	4·8	181	5·0	2·9
6. Consultant psychiatrist outside B/M hospital	43	2·7	56	2·7	99	2·7	3·5
7. Mental hospital	27	1·7	36	1·7	63	1·7	1·3
8. Probation service, remand home, court or prison	22	1·4	4	0·2	26	0·7	0·2
9. Government department	10	0·6	8	0·4	18	0·5	0·1
10. Child guidance unit outside B/M hospital	5	0·3	6	0·3	11	0·3	0·1
11. B/M children's department	1	0·1	3	0·1	4	0·1	0·1
12. Other referrals	108	6·9	130	6·3	238	6·5	5·5
13. General practitioners	656	41·7	840	40·6	1,496	41·1	4·2
14. Outpatient department	547	34·8	754	36·4	1,301	35·7	56·1
Total referrals	2,158	—	2,895	—	5,053	—	3,265
Number of discharged patients involved in above referrals	1,572	—	2,069	—	3,641	—	3,245

Multiple referrals in this table.

Table 21. *Referring agencies.*

3,641 inpatient discharges.

Outpatients

Table 22 shows that 8,499 patients discharged from the outpatients department had been the subjects of 11,031 referrals.

Sixty-four per cent of outpatients were sent up by general practitioners (Cf. chapter nine) and 28·5 per cent were referred to the outpatient department after discharge from the wards (item 2). These two are much the largest of the 18 groups shown in the table. The next largest group is that of spontaneous referrals (7·6 per cent) which mainly comprises patients who walk into the outpatient department without an appointment or an introductory letter from a doctor and ask for attention. They are dealt with by the registrar on duty who, among possible disposals, may make an appointment for them to see a consultant. There was an average of over 200 such spontaneous referrals in each year of the triennium.

Expected differences are shown by the figures for the sexes. More males than females are referred under item 7 (probation service, remand home, court) and item 11 (labour exchanges). More females than males come from the first two (and largest) sources and also from domiciliary visits (item 5: 258 women compared with 87 men).

If the two triennia are compared, it will be seen that spontaneous referrals (group three) were more numerous in the second (they were in fact twice as numerous, 318 having presented themselves in the earlier period and 648 in the later), and that referrals from the Ministry of Pensions (group 17) were much fewer in the later period (150 compared with 23). The large figure in the earlier period was an aftermath of the war. The doubling of the proportion of referrals from the wards (ex-inpatients: item 2) in the later period is largely an artefact produced by an administrative change which takes full account of the hospital's wards as a source of referrals to the outpatient department.

Referring agent	Males		Females		Totals		Totals 49-51
	No.	%	No.	%	No.	%	%
1. General practitioners	2,431	60·6	2,985	66·6	5,416	63·7	60·6
2. Ex-inpatients referred to outpatients' department	1,032	25·7	1,388	30·9	2,420	28·5	13·9
3. Spontaneous	330	8·2	318	7·1	648	7·6	4·1
4. Observation ward	155	3·9	194	4·3	349	4·1	0·5
5. B/M domiciliary service	87	2·2	258	5·8	345	4·1	1·2
6. Psychiatric unit or department of general hospital	168	4·2	174	3·9	342	4·0	2·4
7. Probation service, remand home, court	261	6·5	80	1·8	341	4·0	3·3
8. Non-psychiatric hospital or department	105	2·6	162	3·6	267	3·1	2·9
9. Other voluntary organisations	98	2·4	119	2·7	217	2·6	0·4
10. Consultant psychiatrist on B/M staff	65	1·6	85	1·9	150	1·8	0·6
11. Ministry of Labour and National Service local Labour Exchange ...	102	2·5	13	0·3	115	1·4	2·1
12. Assistance institutions	92	2·3	11	0·2	103	1·2	0·9
13. Consultant psychiatrist not on B/M staff	41	1·0	35	0·8	76	0·9	0·5
14. Mental hospitals	26	0·6	27	0·6	53	0·6	0·3
15. B/M children's department	12	0·3	23	0·5	35	0·4	0·3
16. Industrial medical officer	14	0·3	12	0·3	26	0·3	0·9
17. Ministry of Pensions	21	0·5	2	0·0	23	0·3	1·9
18. Ex-Services welfare organisations	10	0·2	5	0·1	15	0·2	0·5
19. Other referrals	49	1·2	41	0·9	90	1·1	2·7
Total referrals	5,099	—	5,932	—	11,031	—	—
Number of discharged patients involved in above referrals	4,014	—	4,485	—	8,499	—	—

Table 22. Referring agencies

8,499 outpatient discharges.

4. Duration of Stay of Inpatients

It will be seen from table 23 that 60 per cent of inpatients stayed in hospital up to three months and that 40 per cent stayed in longer.

Eighty-one out of 3,641 patients (2·2 per cent) stayed in longer than a year. The hospital's medical committee reviews every quarter the list of patients so retained.

On average, women stayed in about twelve days longer than men, and the duration was slightly longer in the second period (3·9 months) than the first (3·8 months).

Duration of stay is related to diagnosis in table 51 below.

	Males		Females		Total		
					No.	Per cent	
	No.	%	No.	%		52–54	49–51
Under a month ...	255	16·2	286	13·8	541	14·9	18·0
1–3 months	732	46·6	923	44·6	1,655	45·5	45·4
4–8 months	497	31·6	694	33·6	1,191	32·7	31·1
9–12 months ...	69	4·4	104	5·0	173	4·7	3·7
Over a year	19	1·2	62	3·0	81	2·2	1·8
Totals	1,572	100·0	2,069	100·0	3,641	100·0	100·0
Average duration of stay (months) ...	3·7		4·1		3·9		
Average for 1949–51 ...	3·6		4·0		3·8		

Table 23. *Duration of stay in hospital.*

3,641 inpatient discharges.

5. Number of Times Seen: Outpatients

The figures shown in table 24 relate to attendances (at each of which the patient sees a doctor) in the outpatient department in the course of a single admission (defined on page xii). Visits to the hospital for interviews with psychologists, psychiatric social workers and other non-medical staff are not here counted.

It will be seen from table 24 that 42 per cent of patients were seen once only by doctors. Many of these once-seen patients are admitted to the hospital's wards or are referred for admission to other hospitals or to an observation ward. Nearly a quarter (23·6 per cent) attend more than four times. A minority of patients are taken on for systematic psychotherapy or for group therapy.

For all patients, the average number of attendances is 4·7, the figure for women (4·9) being slightly larger than for men (4·4). Attendances were more numerous than in the earlier triennium (average 4·7 compared with 3·1). The difference is partly attributable to the fact that more comprehensive arrangements had been made for group therapy which calls for relatively frequent attendances.

The number of times seen is related to diagnosis in table 52 below.

Number of times seen	Males		Females		Total		
	No.	%	No.	%	No.	Per cent	
						1952–54	1949–51
1	1,764	43·9	1,796	40·0	3,560	41·9	53·2
2	770	19·2	864	19·3	1,634	19·2	17·1
3	344	8·6	444	9·9	788	9·2	8·3
4	221	5·5	295	6·6	516	6·1	5·3
5–6	273	6·8	345	7·7	618	7·3	5·8
7+	642	16·0	741	16·5	1,383	16·3	10·3
Total ...	4,014	100·0	4,485	100·0	8,499	100·0	100·0
Average ...	4·4		4·9		4·7		3·1

Table 24. *Number of times seen.*

8,499 outpatient discharges.

6. Special Investigations: Inpatients

The investigations performed on inpatients are set out in table 25 in descending order of frequency as shown in the totals column. Over 88 per cent of patients have Wasserman or Kahn tests; 1·3 per cent have gastric analyses. It will be noticed that items 4, 5, 10, 14 and 16b are psychological tests. Upon over a quarter (27·3 per cent) electro-encephalograms were taken.

	Investigation	Males		Females		Total	
		No.	%	No.	%	No.	%
1	Wasserman or Kahn ...	1,406	89·4	1,811	87·5	3,217	88·4
2	Erythrocyte sedimentation test	1,393	88·6	1,805	87·2	3,198	87·8
3	Blood count	867	55·2	1,246	60·2	2,113	58·0
4	Verbal intelligence tests*	939	59·7	1,017	49·2	1,956	53·7
5	Non-verbal intelligence tests*	923	58·7	1,005	48·6	1,928	53·0
6	X-ray examinations ...	500	31·8	615	29·7	1,115	30·6
7	Electro-encephalogram ...	462	29·4	531	25·7	993	27·3
8	Cerebro-spinal fluid ...	210	13·4	199	9·6	409	11·2
9	Bacteriological tests ...	136	8·7	178	8·6	314	8·6
10	Tests of deterioration* ...	148	9·4	110	5·3	258	7·1
11	Electro-cardiogram ...	65	4·1	86	4·2	151	4·1
12	Basal metabolic rate ...	28	1·8	96	4·6	124	3·4
13	Glucose tolerance and insulin	32	2·0	64	3·1	96	2·6
14	Differential aptitude tests*	45	2·9	20	1·0	65	1·8
15	Gastric analysis	18	1·1	31	1·5	49	1·3
16*a*	Other special bio-chemical tests	1,067	67·9	1,521	73·5	2,588	71·1
b	Other special psychological tests*	96	6·1	69	3·3	165	4·5
c	Other microscopical tests	88	5·6	105	5·1	193	5·3
d	Other tests	598	38·0	806	39·0	1,404	38·6
	Total	1,572	43·2	2,069	56·8	3,641	100·0
*	Total psychological tests...	2,151		2,221		4,372	

Table 25. *Special investigations.*

3,641 inpatient discharges.

7. Special Treatments: Inpatients

It will be seen from table 26 that ten forms of special treatment are listed in a descending order of the totals of which eight are physical and two psychological. In the matter of physical treatments, the joint hospital's policy is conservative. All inpatients are thoroughly investigated from the physical standpoint. Their personal problems are fully talked over with the registrar responsible for each case and their social problems with a psychiatric social worker. Decisions as to treatment and disposal are made by the member of the senior staff into whose beds patients are admitted. All patients receive some measure of psychotherapy.

The figures showing physical treatments given during the two triennia are generally similar. The most noteworthy difference is for leucotomies which are sparingly performed, each case being care-

fully considered at a special "leucotomy conference". It will be seen (line 6) that 2·5 per cent of cases (41 men and 50 women) were leucotomised, the figure being higher than that for the earlier triennium (1·1 per cent: four men and thirty women). A recently completed neurosurgical unit (jointly administered with Guy's Hospital and opened on 1 October, 1952: see chapter eight) in the Maudsley's curtilage provides perfect surgical facilities.

It will be seen that hypnosis, as to the value of which in psychiatry misleading accounts often appear in the popular press, is little used. Group therapy is less employed for inpatients than outpatients, for whom it is systematically provided.

The distribution of special treatments by diagnosis is discussed in section 12 of chapter 4.

Special treatments (multiple treatments included)	Males		Females		Total		
	No.	%	No.	%	No.	Per cent	
(a)	(b)	(c)	(d)	(e)	(f)	(g)	
						52-54	49-51
1 E.C.T. and electro-narcosis ...	357	22·7	718	34·7	1,075	29·5	28·5
2 Special drug treatment	241	15·3	284	13·7	525	14·4	15·1
3 Deep insulin ...	96	6·1	114	5·5	210	5·8	6·1
4 Modified insulin	42	2·7	124	6·0	166	4·6	5·8
5 Drug abreaction	59	3·8	63	3·0	122	3·4	3·5
6 Leucotomy ...	41	2·6	50	2·4	91	2·5	1·1
7 Continuous narcosis	15	1·0	18	0·9	33	0·9	1·1
8 Group therapy ...	19	1·2	12	0·6	31	0·9	0·6
9 Hypnosis ...	10	0·6	11	0·5	21	0·6	0·8
10 G.P.I. treatment	3	0·2	2	0·1	5	0·1	0·4
Total patient-treatments	883		1,396		2,279		
Total patients treated	762	48·5	1,155	55·8	1,917	52·7	51·6
Patients who received no special treatment	810	51·5	914	44·2	1,724	47·3	48·4
Totals	1,572	100·0	2,069	100·0	3,641	100·0	100·0

Table 26. *Special treatments.*

3,641 inpatient discharges.

8. Outcome of Treatment : In-Patients

It will be seen from table 27 that, over the triennium, nearly four-fifths (79·2 per cent) of discharged inpatients were considered to have benefited from treatment; and in assessing this figure it should be remembered that some patients discharged themselves against advice, often before full benefit had been obtained.

Nearly a half (48·4 per cent) had recovered or had much improved; three out of ten (30·8 per cent) had improved or slightly improved; and a little over a fifth (20·8 per cent) had not benefited (no change, worse, died, or suicide).

These proportions were fairly constant in the three years of the triennium. In so far as a trend is discernible, it is in the direction of better results, the figure for the first of the three groups (recovered or much improved) being five per cent higher for 1954 (50·9 per cent) than for 1952 (45·6 per cent).

Throughout the triennium, the results were slightly better for women than men: in each of the three years, the proportion of women recorded in the first group (recovered or much improved) was higher than of men; and the proportion in the third group (no change, died, worse or suicide) was lower.

The results were also slightly better for the triennium as a whole than for the earlier triennium.

But little importance can be attached to these comparisons. The joint hospital's inpatients are a highly selected group and it would be easy to show better results if a policy were adopted of excluding from admission patients for whose illnesses the prognosis was assessed as bad. The results are also influenced by the hospital's special activities. For example, the joint hospital contains a geriatric unit. If the allocation of beds to this unit were enlarged at the expense of units dealing with young adults, many of whom make good recoveries, the figures as to outcome would suffer.

The assessment of outcome, moreover, is a mainly qualitative judgment. External standards—such as a man's ability to return to work—are not always available, nor are they wholly satisfactory. Though uniformity of standards is difficult to attain, the joint hospital favours caution.

The outcome of treatment is related to diagnosis in tables 53 and 54 below.

Year	Condition when discharged	Males		Females		Total		Triennium 1949-51
		No.	%	No.	%	No.	%	%
1952	1. Recovered or much improved	233	41·7	328	48·8	561	45·6	
	2. Improved or slightly improved	177	31·7	204	30·4	381	30·9	
	3. No change, worse, died or suicide	149	26·6	140	20·8	289	23·5	
	Total	559	100·0	672	100·0	1,231	100·0	
1953	1. Recovered or much improved	233	47·2	347	49·8	580	48·7	
	2. Improved or slightly improved	160	32·5	218	31·3	378	31·8	
	3. No change, worse, died or suicide	100	20·3	132	18·9	232	19·5	
	Total	493	100·0	697	100·0	1,190	100·0	
1954	1. Recovered or much improved	239	46·0	382	54·6	621	50·9	
	2. Improved or slightly improved	150	28·8	211	30·1	361	29·6	
	3. No change, died, worse or suicide	131	25·2	107	15·3	238	19·5	
	Total	520	100·0	700	100·0	1,220	100·0	
Triennial Totals	1. Recovered or much improved	705	44·8	1,057	51·1	1,762	48·4	47·5
	2. Improved or slightly improved	487	31·0	633	30·6	1,120	30·8	30·0
	3. No change, worse, died or suicide	380	24·2	379	18·3	759	20·8	22·5
	Total	1,572	100·0	2,069	100·0	3,641	100·0	100·0

Table 27. Outcome of treatment.

3,641 inpatient discharges.
Years 1952, 1953 and 1954 separately shown.

9. Disposals: Inpatients

From table 28 it will be seen that the disposals have been grouped into four categories, namely (A) to the private doctor, (B) for further treatment or supervision at the joint hospital, (C) for residential treatment or accommodation (hospital or institution) outside, and (D) other disposals.

It will be seen that 4,667 disposals were made of 3,641 inpatients. A little over a third (34·6 per cent) were referred back to their private doctors; for two-thirds (66·9 per cent) the joint hospital continued to take responsibility either in its outpatient department, its clinic for the epilepsies or its day hospital; a little over a tenth (10.5 per cent) were sent for residential treatment outside; and other disposals were made.

There are no conspicuous differences between the disposals of the two sexes (men comprising 43·2 per cent of all patients and disposals of men comprising the same percentage of all disposals) or between the two triennia. The day hospital, opened in 1953, admitted no males; sixteen women were referred to it on being discharged from the wards.

Disposals (multiple)	Males		Females		Total		Percentages in Groups *A*—*D*	
	No.	%	No.	%	No.	%	52-54	49-51
A. To private doctor	521	33·1	739	35·7	1,260	34·6	34·6	32·0
B. *Further treatment or supervision at joint hospital*								
To outpatients' department for treatment or supervision ...	959	61·0	1,321	63·8	2,280	62·6		
To clinic for epilepsies	73	4·6	67	3·2	140	3·8	66·9	62·4
Day hospital	—	—	16	0·8	16	0·4		
C. *For residential treatment outside*								
Admission to observation ward recommended	65	4·1	74	3·6	139	3·8		
Admission to mental hospital recommended	42	2·7	51	2·5	93	2·6		
Admission to non-mental hospital recommended	29	1·8	43	2·1	72	2·0		
Admissions to residential institutions recommended	23	1·5	43	2·1	66	1·8		
Admission to other psychiatric unit recommended	8	0·5	4	0·2	12	0·3	10·5	10·9
D. Other disposals	298	19·0	291	14·1	589	16·2	16·2	13·1
Total disposals	2,018	43·2	2,649	56·8	4,667	100·0		
Total patients	1,572	43·2	2,069	56·8	3,641	100·0		

Table 28. *Disposal.*

3,641 inpatient discharges.

10. Disposals: Outpatients

From table 29 it will be seen that the disposals have been assembled in three groups: (A) referred to private doctor, (B) admission to hospital or institution recommended, and (C) other disposals and no special disposal. In the earlier triennium, about a third of all referrals were contained in each group. But in the second period, the distribution changed. More patients were disposed of (groups A and C) otherwise than by admission to hospitals or institutions (group B). In the first triennium, 34 per cent of patients were so admitted (group B), in the second under 29 per cent.

These changes in disposal are compatible with the hypothesis that on the whole the patients dealt with in the second period were less acutely ill than those dealt with in the first, and with the possibility (discussed in section 14 of chapter four) that it may be a trend of the health services that more neurotic, psychopathic, occupationally unstable, and socially maladjusted types unsuitable for admission are being referred to psychiatric units and mental hospitals. Thus, admissions of outpatients to the joint-hospital's wards made 15·2 per cent of the second period's disposals compared with 22·6 per cent of the first's (Cf. table 57 below).

Disposals (multiple)	Males		Females		Total		Percentages in groups *A—C*	
	No.	%	No.	%	No.	%	52-54	49-51
A. Referred to private doctor	1,610	40·1	1,827	40·7	3,437	40·4	40·4	35·1
B. Admission to hospital or institution recommended								
Admitted to joint hospital	545	13·6	750	16·7	1,295	15·2		
Admitted to day hospital	—	—	67	1·5	67	0·8		
Admitted to mental hospital as Voluntary Patient recmnd. ...	221	5·5	337	7·5	558	6·6		
Admission to observation ward recommended	119	3·0	195	4·3	314	3·7		
Other residential treatment recommended	110	2·7	75	1·7	185	2·2	28·5	34·0
C. Other								
No special disposal	1,130	28·2	1,326	29·6	2,456	28·9		
Other disposals	765	19·1	584	13·0	1,349	15·9	44·8	32·7
Total disposals	4,500	—	5,161	—	9,661			
Total patients	4,014	—	4,485	—	8,499	—		
Disposals may be multiple. Hence percentages exceed a hundred								

Table 29. *Disposal.*

8,499 outpatient discharges.

11. Mode of Leaving

Discharges against advice among inpatients and (to a lesser extent) lapses among outpatients can be regarded as failures of treatment. They can be considered under the heading "Mode of Leaving".

Inpatients who discharge themselves against advice

In the first of these reports it was shown that, of 3,245 inpatient discharges, 448 (13·8 per cent) were discharged against advice.

This important item, though recorded, was unfortunately not punched in the second triennium and no figures are available.

Lapses, deaths and suicides among outpatients

A fifth of all outpatients (1,764 out of 8,499) lapsed (table 30). The figure (20·8 per cent) is fractionally larger than for the first triennium (19·3 per cent) which is not incompatible with the view that on the whole less severe cases were dealt with in the second than in the first period. A patient is counted as having lapsed if, an appointment having been made with him at an earlier attendance, he does not keep the appointment, does not notify the hospital beforehand, and makes no further contact with the hospital arising from his failure to keep the appointment. The matter is dealt with in terms of diagnosis in tables 60 and 61 below.

Deaths and suicides which occur outside hospital when the patient is attending as an outpatient, thus closing his case, are counted as a mode of leaving. Twenty-five patients died and seventeen (eleven of them women) committed suicide.

The figures for mode of leaving differ little from those of the earlier triennium. Then also the lapse-rate was slightly higher for men than women (20·5 compared with 18·1 per cent), a difference which may be partly due to the larger number of occupationally unstable, casual and alcoholically addicted psychopaths among men than women. Some of these present themselves in the outpatient department as spontaneous referrals (without a doctor's letter) where they are seen by the take-in registrar who commonly makes an appointment for them to see a consultant. This appointment they often do not keep (c.f. difference in lapse rates between men and women shown in table 61 in respect of patients with pathological and immature personalities, sexual deviations and addictions to alcohol and drugs).

Mode of leaving	Male		Female		Total		49-51
	No.	%	No.	%	No.	%	%
Discharged	3,129	78·0	3,564	79·5	6,693	78·7	80·5
Lapsed	868	21·6	896	20·0	1,764	20·8	19·3
Died	11	0·3	14	0·3	25	0·3	0·1
Suicide	6	0·1	11	0·2	17	0·2	0·1
Total	4,014	100·0	4,485	100·0	8,499	100·0	100·0

Table 30. *Mode of leaving.*

8,499 outpatient discharges.

12. Social Case-Work Undertaken

Of 3,641 inpatients, social work was undertaken for 1,418 or 39 per cent; and of 8,499 outpatients for 1,402 or 16·5 per cent.

The percentages are slightly smaller than those for the earlier triennium which were 44·7 and 17·7 per cent for in- and outpatients. The difference may be partly attributable to an improvement in the housing position in South London.

CHAPTER FOUR

DIAGNOSIS

This chapter is arranged like chapter four of the first of these reports (c.f. pp. 48 and 49 of that report). The same nineteen-point diagnostic list is used and also the same four major assortments of the World Health Organisation's international list of diseases and causes of death. This useful condensation brings out differences of a general kind which can be missed in detailed classifications. The figures refer throughout not to admissions but to discharges (see table 1), and the code numbers are those of W.H O's international list.

1. Outpatients, Inpatients and Total Discharges

In this section the distributions by diagnosis of the above three groups are discussed. For simple reasons, which are explained, the percentage distributions of out- and inpatient discharges are different. These two groups are pooled in the figures for total discharges which therefore show an intermediate distribution. The features of each of these three groups are set out in two tables: the first shows the four major assortments above-mentioned and the second the nineteen point list explained in the first chapter (p. 4).

(*a*) *Outpatients*

The psychiatric characteristics of the 8,499 outpatients seen during the triennium are largely determined by the referring habits of the general practitioners of South London. Sixty-four per cent of the outpatients discharged during the period were directly referred to the Outpatients' Department in this way (table 22) and another substantial fraction was *indirectly* referred through the admission to the outpatient department of ex-inpatients, who before entering the wards had been referred to the hospital by general practitioners. Outpatients are not selected or screened by hospital agencies though a selective principle may be at work outside (see p. 2). Any doctor or organisation can refer cases, and an increasing number (7·6 per cent in the second triennium compared with 4·1 per cent in the first: Cf. table 22) of patients present themselves in the outpatient department on their own initiative without an introductory letter or appointment. These cases are listed as "spontaneous referrals".

The following features of table 31 are noticeable:

Psychoses form a little over a quarter (27·2 per cent) of all discharges, being better represented among women (30·9 per cent) than men (23·1 per cent). Psychoneuroses contribute a little under a half (47·2 per cent) of all discharges and are again better represented among women (over half) than men (41·6 per cent): but the deficits among males in these two assortments are offset by a large

excess in the third assortment wherein nearly a quarter (24·7 per cent) of all male outpatients is included. Of the four assortments, the sexes are most equally represented among the miscellaneous cases.

If the two triennia are compared, it will be seen that, in the second, small surpluses in the first three ("psychiatric") assortments are offset by a deficit in the "miscellaneous" group.

The more detailed breakdown in table 32, wherein figures relating to totals under a hundred are in brackets, shows that the surpluses of women over men in the first two assortments are mainly due to their excess in the two groups of depressions which, from the numerical standpoint, are large. Over a third (34·2 per cent) of all female outpatients fall into these two groups compared with 19·8 per cent of males. In the first assortment of psychoses, the excess of women over men is also raised by their larger contribution to the group of "other psychoses" (4·8 compared with 2 per cent): and in the second assortment of psychoneuroses, women exceed men in the group of hysterias (5·2 compared with 2·5 per cent). On the other hand males slightly exceed females in the (second largest) group of anxiety states as they also did by (two per cent) in the first triennium.

The massive excess of men over women in the third assortment (disorders of character) is mainly accounted for by large surpluses in the group of pathological and immature personalities and of sexual deviations, and by a smaller surplus in that of alcoholics and drug addicts.

To the hospital's outpatient population, schizophrenics, who form such a large fraction of the static populations of mental hospitals, contributed in both triennia between 8 and 9 per cent.

Between the two triennia, the differences in the percentages are rather surprisingly small.

Code	Diagnostic assortment	1952–1954						1949–51
		Males		Females		Totals		(7,713 patients)
		No.	%	No.	%	No.	%	
300–309	Psychoses	927	23·1	1,386	30·9	2,313	27·2	25·6
310–318	Psychoneurotic disorders ...	1,671	41·6	2,337	52·1	4,008	47·2	45·9
320–325	Disorder of character, etc. ...	992	24·7	374	8·3	1,366	16·1	15·8
Miscellaneous : Outside Nos. 300–325 ...		424	10·6	388	8·7	812	9·5	12·7
Total		4,014	100·0	4,485	100·0	8,499	100·0	100·0

Table 31. *Diagnosis by sex.*

8,499 outpatient discharges in four major assortments.

Diagnostic group	Males		Females		Totals (7,713 patients)		
	No.	%	No.	%	No.	%	49-51
Schizophrenic disorders	371	9·2	364	8·1	735	8·6	8·0
Manic-depressive reaction	333	8·3	604	13·5	937	11·0	10·3
Paranoia and paranoid states	45	1·1	51	1·1	(96	1·1	1·0)
Senile psychoses, etc.	61	1·5	102	2·3	163	1·9	1·9
Organic disorders of the C.N.S.	31	0·8	44	1·0	(75	0·9	0·6)
Psychoses resulting from epilepsy ...	5	0·1	4	0·1	(9	0·1	0·2)
Other psychoses ...	81	2·0	217	4·8	298	3·5	3·7
Anxiety	637	15·9	651	14·5	1,288	15·2	15·3
Hysteria	101	2·5	277	6·2	378	4·5	5·5
Obsesive compulsive reaction	111	2·8	120	2·7	231	2·7	2·9
Neurotic depressive reaction	462	11·5	930	20·7	1,392	16·4	15·3
Other psychoneuroses	360	9·0	359	8·0	719	8·5	6·8
Pathological and immature personalities	528	13·2	269	6·0	797	9·4	9·2
Sexual deviations ...	237	5·9	11	0·2	248	2·9	2·3
Non-sexual delinquency or crime	47	1·2	23	0·5	(70	0·8	0·9)
Alcoholic and drug addictions	110	2·7	37	0·8	147	1·7	1·7
Primary childhood disorders	21	0·5	4	0·1	(25	0·3	0·3)
Mental deficiency ...	49	1·2	30	0·7	(79	0·9)	1·4
Miscellaneous: Diagnosis outside Code Nos. 300-325	424	10·6	388	8·7	812	9·6	12·7
Total	4,014	100·0	4,485	100·0	8,499	100·0	100·0

Table 32. *Diagnosis by sex.*

8,499 outpatient discharges in nineteen groups.
(Figures relating to totals of under a hundred are in brackets.)

(*b*) *Inpatients*

The distribution by diagnostic group of the hospital's 3,641 inpatients, unlike that of its outpatients, is shaped by the selective activities of the members of the senior staff. The two main principles

of selection are that the prognosis should be reasonably good (the case being deemed "early and remediable" though the disturbance may be severe) and that the illness should have teaching interest.

Table 33 gives the distribution by four major diagnostic assortments. Comparison with the similarly arranged table 31 for outpatients shows conspicuous but expected differences. In the assortment of psychoses are 47·5 per cent of inpatients compared with 27·2 per cent of outpatients, the differences between the sexes (much influenced for inpatients by the bed accommodation in the acute wards) being smaller for in- than outpatients. On the other hand, there are relatively fewer in- than outpatients in all the other assortments. As among outpatients, females exceed males in the second assortment of psychoneurotic disorders, and males exceed females in the third, disorders of character; but in neither is the difference as pronounced as among outpatients. Patients in these two assortments are mostly distributed throughout the wards for mild or recovering cases.

Between the two triennia, differences are small: rather more psychotics and miscellaneous cases were discharged in the second period and more psychoneurotics and patients with disorders of character in the first.

If table 34, showing the distribution of inpatients by the nineteen-point list (wherein figures relating to totals under fifty are in brackets), be compared with table 32 which shows the corresponding distribution for outpatients, the following differences can be seen:

All the psychoses are better represented among in-than outpatients. The differences are most pronounced in respect of schizophrenia, manic-depressive disorders and "other psychoses". Manic-depressives (712 patients) form the largest of the nineteen groups—as much larger than the group of neurotic depressives (565 patients) as the latter group is larger than the former among outpatients (1,392 against 937 patients). The group of psychoses in which inpatients exceed outpatients by the smallest margin is that of paranoia and paranoid states; these cases, if long-standing, are unamenable to treatment and may be better dealt with as outpatients.

The lesser representation of psychoneurotics among in- than outpatients is most conspicuous in respect of patients with anxiety and "other psychoneuroses" who do not often need inpatient treatment. The representation of hysterics, obsessive-compulsive and neurotic-depressive cases is much the same among in- and outpatients.

Of patients with disorders of character (poorly represented in the wards) only two groups of inpatients exceed fifty. But their representation contrasts with that of outpatients. The first group comprises patients with pathological and immature personalities (9·4 per cent among outpatient discharges). These are not regarded as good

candidates for admission to the wards from which they contribute but 4·6 per cent of discharges. The second group is that of alcohol and drug addicts of whom the former are treated in a special ward-unit and are readily admitted as inpatients. As outpatients they number 1·7 per cent of total discharges and as inpatients, 2·1 per cent. The balance was tilted in the same way during the first triennium: as outpatients, alcohol or drug addicts numbered 1·7 per cent, of all discharges; as inpatients, 2·4 per cent.

Over the two triennia (two right-hand columns of table 34) the percentage distributions by diagnosis are rather surprisingly similar. The largest difference is one of 2·1 per cent for manic-depressives.

Code	Diagnostic assortment	1952-1954						49-51
		Males		Females		Total		3,245 pt'nts
		No.	%	No.	%	No.	%	%
300-309	Psychoses ...	730	46·4	999	48·3	1,729	47·5	44·7
310-318	Psychoneurotic disorders ...	480	30·5	768	37·1	1,248	34·3	35·8
320-325	Disorders of character, etc. ...	188	12·0	103	5·0	291	8·0	9·7
Miscellaneous: Outside Nos. 300-325		174	11·1	199	9·6	373	10·2	9·8
Total		1,572	100·0	2,069	100·0	3,641	100·0	100·0

Table 33. *Diagnosis by sex.*

3,641 inpatient discharges in four major assortments.

Diagnostic group	Males		Females		Totals		
	No.	%	No.	%	No.	%	49-51 3,245 p't'nts
Schizophrenic disorders	263	16·7	290	14·0	553	15·2	15·0
Manic-depressive reaction	271	17·2	441	21·3	712	19·6	17·5
Paranoia and paranoid states	28	1·8	24	1·2	52	1·4	1·2
Senile psychosis and psychosis with cerebral arteriosclerosis	41	2·6	42	2·0	83	2·3	2·3
Organic disorders of the central nervous system	22	1·4	51	2·5	73	2·0	2·1
Psychosis resulting from epilepsy	9	0·6	8	0·4	(17	0·5	0·4)
Other psychoses ...	96	6·1	143	6·9	239	6·6	6·0
Anxiety	108	6·9	142	6·9	250	6·9	7·5
Hysteria	52	3·3	125	6·0	177	4·9	5·5
Obsessive compulsive reaction	46	2·9	34	1·6	80	2·2	3·1
Neurotic depressive reaction	203	12·9	362	17·5	565	15·5	15·6
Other psychoneuroses	71	4·5	105	5·1	176	4·8	4·2
Pathological and immature personalities	99	6·3	69	3·3	168	4·6	5·9
Sexual deviations ...	10	0·6	4	0·2	(14	0·4	0·6)
Non-sexual delinquency or crime	9	0·6	4	0·2	(13	0·3	0·3)
Alcoholic and drug addictions	59	3·8	19	0·9	78	2·1	2·4
Primary childhood disorders	4	0·3	6	0·3	(10	0·3	0·4)
Mental deficiency ...	7	0·4	1	0·1	(8	0·2	0·2)
Miscellaneous ...	174	11·1	199	9·6	373	10·2	9·8
Total	1,572	100·0	2,069	100·0	3,641	100·0	100·0

Table 34. *Diagnosis by sex.*

3,651 inpatient discharges in nineteen groups.
(Figures relating to totals under fifty are in brackets.)

(*c*) *Total Discharges*

The figures for total discharges are the sum of the corresponding figures for out- and inpatients shown in tables 31 to 34. They involve some duplication of discharges: a discharge from the outpatient department and from a ward may both be counted for the same

individual, one following the other as part of a routine sequence; or there may be more than one admission both to the wards and the outpatient department during the triennium. The amount of the duplication here involved can be conveyed by saying that 9,357 individual in- and outpatients were concerned in 12,140 discharges (Cf. table 1).

Table 35 shows separately the distribution of all discharges, according to the four major assortments, in each of the three years of the triennium and also in the triennium as a whole. It will be seen how constant from year to year were the percentages in each assortment. The maximum fluctuation over the three years for males and females combined is one of 1·7 per cent in respect of the percentages of psychoneurotics discharged in 1952 and 1954—43·9 and 42·2 respectively. If the sexes are separately considered, the largest fluctuation in the table is that of 4·2 per cent relating to male psychoneurotics in 1952 and 1954 (40·4 and 36·2 per cent). Over the three years, there were most discharges (4,142) in 1953 and fewest (3,922) in 1952—a difference of 220.

Table 36 shows in- and outpatient discharges, consolidated for the triennium and distributed according to the nineteen-point list. The table has no noteworthy features, the percentages being necessarily intermediate between those shown in tables 32 and 34 for out- and inpatients. It is here produced to provide a possible basis of comparison for future reports. It also provides the most representative synopsis of the hospital's total activities, and it forms the base for several of the later tables in this chapter.

Year	Code	Diagnostic assortment	Males		Females		Total	
			No.	%	No.	%	No.	%
1952	300–309	Psychoses	510	28·4	766	36·0	1,276	32·5
	310–318	Psychoneuroses	725	40·4	997	46·9	1,722	43·9
	320–325	Disorders of character, etc.	358	19·9	177	8·3	535	13·7
	Outside 300–325 ...	Miscellaneous	202	11·3	187	8·8	389	9·9
		Total	1,795	100·0	2,127	100·0	3,922	100·0
1953	300–309	Psychoses	589	31·2	801	35·5	1,390	33·6
	310–318	Psychoneuroses	735	39·0	1,079	47·8	1,814	43·8
	320–325	Disorders of character, etc.	378	20·1	153	6·8	531	12·8
	Outside 300–325 ...	Miscellaneous	183	9·7	224	9·9	407	9·8
		Total	1,885	100·0	2,257	100·0	4,142	100·0
1954	300–309	Psychoses	558	29·3	818	37·7	1,376	33·8
	310–318	Psychoneuroses	691	36·2	1,029	47·4	1,720	42·2
	320–325	Disorders of character, etc.	444	23·3	147	6·8	591	14·5
	Outside 300–325 ...	Miscellaneous	213	11·2	176	8·1	389	9·5
		Total	1,906	100·0	2,170	100·0	4,076	100·0
Tri-ennial total	300–309	Psychoses	1,657	29·7	2,385	36·4	4,042	33·3
	310–318	Psychoneuroses	2,151	38·5	3,105	47·4	5,256	43·3
	320–325	Disorders of character, etc.	1,180	21·1	477	7·3	1,657	13·6
	Outside 300–325 ...	Miscellaneous	598	10·7	587	8·9	1,185	9·8
		Total	5,586	100·0	6,554	100·0	12,140	100·0

Table 35. *Diagnosis by sex.*

12,140 in- and outpatient discharges by separate years and for triennium.

Four major assortments.

Code Nos.	Diagnostic group	Males		Females		Totals		
		No.	%	No.	%	No.	%	49-51
300	Schizophrenic disorders	634	11·4	654	10·0	1,288	10·6	10·0
301	Manic-depressive reaction	604	10·8	1,045	15·9	1,649	13·6	11·6
303	Paranoia and paranoid states	73	1·3	75	1·1	148	1·2	(1·1)
304, 306	Senile psychosis and psychosis with cerebral arteriosclerosis	102	1·8	144	2·2	246	2·0	2·2
305, 307, 308.0, 308.2	Organic disorders of the central nervous system	53	1·0	95	1·4	148	1·2	1·1
308.1	Psychosis resulting from epilepsy	14	0·3	12	0·2	(26	0·2	0·2)
302, 309	Other psychoses	177	3·2	360	5·5	537	4·4	4·0
310	Anxiety	745	13·3	793	12·1	1,538	12·7	14·1
311	Hysteria	153	2·7	402	6·1	555	4·6	5·8
313	Obsessive compulsive reaction	157	2·8	154	2·3	311	2·6	2·8
314	Neurotic depressive reaction	665	11·9	1,292	19·7	1,957	16·1	15·1
312, 315–18	Other psychoneuroses	431	7·7	464	7·1	895	7·4	6·7
320	Pathological and immature personalities	627	11·2	338	5·2	965	7·9	9·2
320.6	Sexual deviations	247	4·4	15	0·2	262	2·2	2·1
320.7	Non-sexual delinquency or crime	56	1·0	27	0·4	(83	0·7	0·9)
322, 323	Alcoholic and drug addictions	169	3·0	56	0·9	225	1·8	1·8
324	Primary childhood disorders	25	0·5	10	0·2	(35	0·3	0·4)
325	Mental deficiency	56	1·0	31	0·5	(87	0·7	1·3)
Miscellaneous—outside numbers 300–325		598	10·7	587	9·0	1,185	9·8	9·6
Total		5,586	100·0	6,554	100·0	12,140	100·0	100·0

Table 36. *Diagnosis by sex.*

12,140 in- and outpatient discharges in nineteen groups.
(Figures relating to totals under a hundred are in brackets.)

2. Diagnostic Group of "Miscellaneous" Cases

As shown in table 35 there were included among the 12,140 in- and outpatient discharges 1,185 cases classified as "miscellaneous" because their principal diagnosis fell outside the rubrics 300-325. A breakdown of this series is given in table 37.

The remarks made about table 38 of the first triennial report apply to this table. With the exception of the categories *diagnosis uncertain and no psychiatric abnormality* (as to which the comments made in the earlier report need not here be repeated), the rubrics are arranged in a descending order of the total figures. It will be seen that 891 out of the 1,185 miscellaneous cases (75·2 per cent) are concentrated in fourteen rubrics. The remaining quarter are thinly spread over a wide range; 294 cases are distributed over 121 rubrics.

Code No.	Rubric	Males	Females	Total
353	Epilepsy (without psychosis) ...	78	64	142
688	Complications of the puerperium	0	98	98
326	Unspecified disorder of character, etc.	46	30	76
780	Symptoms referable to C.N.S., etc.	42	32	74
355	Other diseases of the brain ...	15	18	33
083	Late effects of acute infectious encephalitis	19	8	27
350	Paralysis agitans	12	8	20
025	General paralysis of the insane ...	14	5	19
852	Concussion...	18	1	19
345	Multiple sclerosis	3	15	18
334	Other vascular lesions affecting the C.N.S.	7	10	17
193	Malignant neoplasm of brain and C.N.S.	8	7	15
	Diagnosis uncertain	85	62	147
	No psychiatric abnormality ...	97	89	186
Total (14 rubrics)		444	447	891
Remainder distributed over 121 rubrics ...		154	140	294
Total		598	587	1,185
Percentage of all discharges (5,586 males, 6,554 females, 12,140 total)		10·7	9·0	9·8

Table 37. *"Miscellaneous" cases distributed over* 135 *rubrics.*

1,185 cases among 12,140 in- and outpatient discharges.

3. Principal Accessory Chronic Conditions and Complications

These conditions, which can be diagnosed as supplementary to the "principal disease", were considered at some length on pages 58-61 of the first of these reports. They serve the useful purpose of widening the psychiatrist's diagnostic scope. Of the first triennium's figures the point was made that 73 per cent of the accessory chronic conditions fell within the rubrics 300-326 and were, in fact, accessory psychiatric diagnoses.

Of the 12,140 in- and outpatient discharges recorded in the second triennium, principal accessory chronic conditions were diagnosed (in addition to the "principal disease") in 3,539 (29·1 per cent). The distribution of these cases is shown in table 38.

It will be seen that compared with the first triennium a slightly smaller proportion of the diagnosed accessory conditions fell into the "psychiatric" (or first three) categories—69·4 instead of 73·3 per cent. The deficit in the second period is most pronounced in the assortment of the psychoneuroses which contributed 29·9 per cent of accessory conditions compared with 35·9 per cent in the first period. This deficit is to a small degree offset by small surpluses in respect of the first and third assortments—psychoses and disorders of character.

The distribution of accessory diagnoses of solely psychiatric illnesses in the two triennia can be better appreciated when the fourth assortment of table 38, which comprises non-psychiatric conditions, is omitted as in table 39. From this table, it will be seen that among 2,457 cases 2·1 per cent more psychoses were diagnosed in the second triennium than in the first; and 4·5 per cent more disorders of character. The position in respect of the latter is, therefore, as follows:

Fewer were admitted to the wards in the second period (table 33), but slightly more were dealt with as outpatients (table 31); and among 2,457 in- and outpatient discharges of whom accessory psychiatric conditions were recorded, 4·5 per cent more cases than in the earlier triennium were assessed as having disorders of character. It will be interesting to see whether this trend will be sustained in the future.

Included among the disorders of character behaviour and intelligence are 115 cases of sexual deviation (98 males and 17 females). Corresponding figures for the first triennium were 53 (42 males and 11 females). These rather small figures may be of interest in view of the importance attached by some schools of psychiatry to homosexuality as a factor predisposing to many forms of psychopathy.

Major assortment	Males	Females	Totals		
			No.	%	1949-51
1. 300–309 Psychoses: 12 diagnostic groups ...	102	161	263	7·4	6·4
2. 310–318 Psychoneuroses: 9 diagnostic groups	429	628	1,057	29·9	35·9
3. 320–325 Disorders of character, etc.: 15 groups	638	499	1,137	32·1	31·0
4. Any rubric outside the series 300–325: 242 groups	487	595	1,082	30·6	26·7
Totals : 278 diagnostic groups (rubrics) ...	1,656	1,883	3,539	100·0	100·0

Table 38. *Principal accessory chronic conditions.*

3,539 discharges distributed over 278 rubrics in four major assortments.

Major assortment	Percentage 1952–1954 2,457 patients	Percentage 1949–1951 1,350 patients
300–309 Psychoses	10·7	8·6
310–318 Psychoneuroses	43·0	49·6
320–325 Disorders of character, etc.	46·3	41·8
Totals	100·0	100·0

Table 39. *Principal accessory chronic conditions.*

2,457 discharges in three major assortments within rubrics 300–325. Percentages for second triennium compared with first.

4. Age by Diagnosis

It will be seen from table 40 that the average ages of 11,909 in- and outpatient discharges, distributed among fifteen diagnostic groups, range over the wide span of nearly 38 years—from sexual deviations among females (average age 28·9 years) to senile psychoses among females (average age 68·5 years); that the average age of males (39 years) is slightly lower than that of females (40·7 years); that a transverse line separates those groups above from those below

the average; and that the ages of males and females are juxtaposed in adjacent columns in order to facilitate comparisons.

Conditions in which the ages of the sexes differ are paranoia and paranoid states where, though the numbers are small, the average age of males is nine years lower than for females, and hysteria wherein males were on average 4 years older than females. There was a similar difference between the sexes in figures for the first triennium relating to patients with hysteria, a difference which it was suggested might be related to the ages at which claims for compensation for industrial accidents are commonly made by males.

As in the first triennium schizophrenics and pathological and immature personalities constitute young groups in their early thirties; manic-depressives form a definitely older group than do neurotic depressives; young groups are also those comprising sexual deviations, though the figure for females is small.

Diagnostic group	Males		Females		1949–1951 Average age	
	No.	Avge age	Avge age	No.	Males (3,982)	Females (4,313)
1. Sexual deviation ...	247	32·1	28·9	15	30·7	29·7
2. Schizophrenic disorders	634	31·7	34·9	654	30·8	34·8
3. Pathological and immature personalities	627	31·9	31·1	338	31·2	31·4
4. Obsessive-compulsive reaction	157	32·9	36·0	154	33·2	34·7
5. Anxiety	745	34·8	35·8	793	33·7	34·3
6. Other psychoneuroses	431	36·8	36·5	464	35·7	35·5
7. Hysteria	153	38·5	34·6	402	35·7	30·7
8. Neurotic depressive reaction	665	42·7	39·6	1,292	39·0	37·6
9. Paranoia and paranoid states	73	42·4	51·4	75	—	—
10. Alcoholic and drug addictions	169	42·8	45·2	56	43·5	44·6
11. Manic-depressive reaction	604	49·9	47·8	1,045	47·2	46·1
12. Organic disorders of the C.N.S.	53	49·2	51·9	95	—	—
13. Other psychoses ...	177	55·8	55·1	360	55·0	53·7
14. Senile psychoses, etc. ...	102	67·6	68·5	144	64·5	64·8
15. Miscellaneous	598	39·2	38·8	587	37·4	38·3
Total	5,435	39·1	40·7	6,474	37·2	39·2

Table 40. *Age by diagnosis.*

11,909 in- and outpatient discharges in 15 diagnostic groups.

5. Marital Status by Diagnosis.

Two features relating to marital status have been isolated from comprehensive tables: the proportion of single (never married) patients, and the incidence of broken marriages. The latter was not examined in the first triennial report, but both have been recently discussed by the late Dr. Vera Norris (*Journal of Mental Science*, July 1956, vol. 102, No. 428).

The larger overall percentage of single males than of single females was discussed in section three of chapter two.

Table 41 (which is similar to table 45 of the first report, being arranged in an ascending order of the average ages of male groups) again brings out the point made before that, while a higher proportion of single patients can be expected in younger compared with older age-groups, age is not the sole determining factor.

Thus, between the first five male groups there is a difference of less than 3½ years of age; yet the proportions of single vary between 35·1 per cent for patients with anxiety and 71·1 per cent for those with schizophrenia; and groups 2-7 of women differ by less than 5½ years in average age, while the proportions of single range from less than a quarter (23·6 per cent) among patients with anxiety to over a half (51·2 per cent) among patients with pathological and immature personalities.

It is noteworthy that more than half of the patients with pathological and immature personalities (of whom the average age for both sexes was over thirty) were single.

The fact that on average women are slightly older than men doubtless accounts in part for the lower proportion of single persons among women; for the older a person the greater are the chances of his ever having married. It will be seen, for example, that the proportion of single was lower among men than women in six of the fifteen groups, namely in numbers 11 to 14, in that of hysteria (male hysterics were on average about 4 years older than female), and in that of sexual deviations (diagnosed as a principal disease in but fifteen women); and that, on average, men were older than women in four of these six groups, the exceptions being the groups of organic diseases of the central nervous system (No. 12) and senile psychotics (No. 14).

Table 41 shows that the excess of single among males is most pronounced in the two large groups comprising schizophrenics (difference of over 22 per cent) and patients with anxiety (difference of over 11 per cent): psychiatrists may feel that these differences are understandable in terms of clinical experience. For example, schizoid tendencies could impede the marriage of a girl less than that of a man; and anxiety could impel a girl to seek security in marriage while it could deter a man from undertaking the responsibilities of marriage. There is also a 12 per cent excess of single males over single females in the smaller group of obsessive-compulsive patients.

Diagnostic group	Males			Females		
	No.	Avge age	% single	No.	Avge age	% single
1. Sexual deviation	247	32·1	64·0	15	28·9	93·3
2. Schizophrenic disorders ...	634	31·7	71·1	654	34·9	48·7
3. Pathological and immature personalities	627	31·9	55·4	338	31·1	51·2
4. Obsessive compulsive reaction	157	32·9	44·9	154	36·0	32·7
5. Anxiety	745	34·8	35·1	793	35·8	23·6
6. Other psychoneuroses ...	431	36·8	28·5	464	36·5	26·3
7. Hysteria	153	38·5	29·4	402	34·6	38·6
8. Neurotic depressive reaction	665	42·7	26·3	1,292	39·6	23·1
9. Paranoia and paranoid state	73	42·4	27·8	75	51·4	26·7
10. Alcoholic and drug addictions	169	42·8	18·5	56	45·2	17·9
11. Manic-depressive reaction	604	49·9	22·7	1,045	47·8	25·2
12. Organic disorders of the C.N.S.	53	49·2	20·8	95	51·9	22·3
13. Other psychoses	177	55·8	14·2	360	55·1	23·6
14. Senile psychoses, etc. ...	102	67·6	10·9	144	68·5	16·7
15. Miscellaneous	598	39·2	35·9	587	38·8	24·4
Total	5,435	39·1	38·3	6,474	40·1	29·0

Table 41. *Marital status.*

11,909 in- and outpatient discharges in 15 diagnostic groups. Proportion of single (never-married) patients by diagnosis, average age and sex.

Table 42 shows the number and percentages of broken marriages among nearly eight thousand ever-married in- and outpatient discharges. Age, which (table 41) favours the probability of a marriage ever having been contracted, here favours the chances of a marriage having broken down; for the longer a person has been married the wider the scope for the failure of marriage.

Diagnostic assortment	Males			Females			Total		
	E.M.	D.S.C.	%	E.M.	D.S.C.	%	E.M.	D.S.C.	%
Psychoses	983	74	7·5	1,638	122	7·4	2,621	196	7·5
Psychoneuroses...	1,473	146	9·9	2,290	235	10·3	3,763	381	10·1
Disorders of character, etc. ...	542	109	20·1	228	64	28·1	770	173	22·5
Miscellaneous	390	38	9·7	452	36	8·0	842	74	8·8
Total	3,388	367	10·8	4,608	457	9·9	7,996	824	10·3

Table 42. *Broken marriages* (*divorces, separations and co-habitations*).

7,996 ever-married in- and outpatient discharges in four major assortments.

(E.M.—ever-married; D.S.C.—divorced, separated, cohabiting.)

Table 42 strikingly shows how different is the outcome of marriage in the four major assortments already shown.

It is perhaps surprising that the prospects of enduring marriage among psychotics are, comparatively speaking, so favourable—7·5 per cent broken. This figure is close to the Registrar General's estimate of 7·3 per cent for the general population in the year 1950 (*Statistical Review of England and Wales for the Five Years* 1946-1950, text civil, page 62 ; H.M.S.O. 1954). There is little difference between the psychotic and the miscellaneous cases. Of psychoneurotics ten per cent had sustained broken marriages. But the most conspicuous feature of the table is the high figure of over a fifth (22·5 per cent) of broken marriages among patients with disorders of character, the figure for women being over 28 per cent. This finding is in general accordance with clinical experience and it may to a small extent guide clinical practice. For most psychiatrists regard as an important feature of the psychopathic personality a long-standing difficulty in establishing personal relationships and in making adjustments to social life; and it is possible that the break-down of a marriage might be taken into account as a factor which weighed with a psychiatrist in making a diagnosis of psychopathic personality.

Table 43 shows a 17-point breakdown of the same total figures as appear in table 42. Among noteworthy features are the remarkably low broken-marriage rates among senile psychotics who have been married longest of any group; the lower rates for both sexes of manic-depressive compared with neurotic depressive patients (the figures for the latter being about double those for the former despite the fact that the average age of manic depressives is higher by several years than of the others); the high rate (21·8 per cent) for the fifty-five females with paranoia and paranoid states—a disturbance highly inimical to the happiness of marriage; the relatively high rates in both sexes for hysteria compared with anxiety and obsessive-compulsive neurosis; the understandably high rates for pathological

and immature personalities and for alcoholics and drug addicts; and the relatively low rate for males with sexual deviations—lower than for males with hysteria and neurotic depression. It can be surprising how often exhibitionists and homosexuals, apart from their abnormalities, make good husbands and have loyal wives.

Diagnostic group	Males			Females		
	Ever-married	Divorced, sep. and cohabiting		Ever-married	Divorced, sep. and cohabiting	
		No.	% of ever-married		No.	% of ever-married
Schizophrenic disorders	182	21	11·5	334	42	12·6
Manic-depressive reactions	466	30	6·4	781	49	6·3
Paranoia and paranoid states	52	5	9·6	55	12	21·8
Senile psychoses, etc. ...	90	1	1·1	120	4	3·3
Organic disorders of the C.N.S.	(42	3	7·1)	73	6	8·2
Other psychoses ...	151	14	9·3	275	9	3·3
Anxiety	483	41	8·5	605	42	6·9
Hysteria	108	16	14·8	247	36	14·6
Obsessive-compulsive reaction	86	4	4·7	103	10	9·7
Neurotic depressive reaction	488	66	13·5	994	124	12·5
Other psychoneuroses	308	19	6·2	341	23	6·7
Pathological and immature personalities	278	60	21·6	164	47	28·7
Sexual deviations ...	89	11	12·4	(1	1	100·0)
Non-sexual delinquency or crime	(38	6	15·8)	(17	3	17·6)
Alcoholic and drug addictions	137	32	23·4	(46	13	28·3)
Miscellaneous ...	379	36	9·5	439	34	7·7
Other rubrics within series 300–325 with small numbers of patients	(11	2	18·2)	(13	2	15·4)
Total	3,388	367	10·8	4,608	457	9·9

Table 43. *Broken marriages* (*divorces, separations and cohabitations*).

7,996 ever-married in- and outpatient discharges, in seventeen diagnostic groups.

(Figures relating to totals of less than fifty are in brackets.)

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

Information about numbers of children born alive to the patient's mother was available for 11,458 out of 12,240 discharges, as shown in table 44. The sample included some patients who were illegitimately born and who knew nothing of their sibs.

The Greenwood-Yule corrections (see page 12) have been applied. Figures relating to totals of under a hundred are in brackets.

During the fifty years 1880 to 1930, in the course of which were married the parents of most of the patients shown in the table, the average size of the British family became steadily smaller. Hence an important factor influencing the size of a patient's sibship is the date of his parents' marriage. Hence an association can be expected between the age of the patient and the size of his sibship.

The average ages and average sizes of sibships (which include the patients and sibs born alive to his mother) are shown in the bottom line of table 44. The latter figure (for size of sibship) is slightly smaller for males than females (3·0 compared with 3·1).

It will be seen that if we omit groups with totals of under a hundred, the average size of sibship ranges from 4·5 for the 71 female patients with paranoia and paranoid states (average age 51·4 years; three older groups are shown in this table and in table 40) to 2·0 for the small group of fifteen female patients with sexual deviations who form the youngest of the thirty groups shown in Table 40.

The table shows fairly well the expected association between average age and average size of sibship. But there are exceptions. The most conspicuous is that provided by the group of alcoholics and drug addicts whose average ages (43 years for males and 45 years for females) are above the averages for the sample, but the sizes of whose sibships (2·9 for males and 2·8 for females) are below the averages.

The opposite condition (average age below and size of sibship above the average of the sample) is shown by females with anxiety (age 35·8 years; size of sibship 3·1), and by patients (of both sexes) with neurotic depression, who are close to the average age of the sample but belong to sibships appreciably larger than the average (3·4 for both sexes).

These differences in the sizes of sibships are difficult to interpret. The size of a patient's sibship influences his early life and also reflects the mentalities and attitudes of his parents. The effects of both these factors are more easily seen in children than in adults: the potentially harmful effects on children of excessive parental solicitude are quite different from those of indifference or neglect; but the bearings of these events upon the forms of adult psychiatric illness, though doubtless real enough, are difficult to discern in as undiscriminating a classification of mental disorders as that adopted by the World Health Organisation.

More perceptible, perhaps, in its bearings on the forms of mental illness than the size of the patient's sibship might be his birth order, as to which information will be available in later reports.

Diagnostic group	Males			Females		
	No.	Avge age	Avge family size	No.	Avge age	Avge family size
Schizophrenic disorders ...	597	31·7	2·8	618	34·9	2·8
Manic-depressive reaction	576	49·9	3·4	982	47·8	3·4
Paranoia and paranoid states	66	42·4	3·4	71	51·4	4·5
Senile psychoses	91	67·6	3·9	123	68·5	4·3
Organic disorders of the C.N.S.	51	49·2	3·2	93	51·9	3·9
Psychosis from epilepsy ...	(11	—	1·8)	(10	—	3·7)
Other psychoses	164	55·8	3·8	334	55·1	3·8
Anxiety	700	34·8	3·0	763	35·8	3·1
Hysteria	148	38·5	3·4	382	34·6	2·9
Obsessive-compulsive reaction	150	32·9	2·7	150	36·0	2·9
Neurotic depressive reaction	629	42·7	3·4	1,243	39·6	3·4
Other psychoneuroses ...	421	36·8	3·2	459	36·5	2·8
Pathological and immature personalities	600	31·9	2·6	319	31·1	2·7
Sexual deviations	236	32·1	2·5	15	28·9	2·0
Non-sexual delinquency or crime	(54	—	3·3)	(25	—	3·0)
Alcoholic and drug addictions	156	42·8	2·9	53	45·2	2·8
Primary childhood disorders	(24	—	2·0)	(9	—	1·5)
Mental deficiency	(47	—	2·4)	(26	—	2·0)
Miscellaneous	541	39·2	3·2	521	38·8	3·1
Total	5,262	39·1	3·0	6,196	40·7	3·1

Table 44. *Size of the patient's sibship (including the patient) by diagnosis and average age.*

11,458 in- and outpatient discharges in nineteen groups.
(Greenwood-Yule correction applied to average family size. Figures relating to totals (males and females combined) of under one hundred are in brackets.)

7. Duration of Marriage

Information on this subject was recorded and punched for the second triennium because of its bearings on fertility.

The effective duration of marriage is easy to calculate when there have been no interruptions of the marriage. All that is then needed is the date of the marriage. But when there have been interruptions

such as separations, divorces and deaths of the spouse followed by remarriage, the duration of marriage is difficult to calculate. The task of eliciting this information is excessive for a psychiatric social worker at a preliminary interview; and it overtaxes the patient at such an interview. The results, moreover, when obtained are not always accurate because of the haziness of the memories of many patients about important dates in their lives. But every patient is, as a routine, asked about his marital status and, if ever married, how old he/she was at first marriage. It is an easy matter to calculate the duration of enduring marriage, that is to say of the marriages of those patients who have been married once and who are married when they first attend the hospital. This has been done.

It will be seen from table 45 that information as to duration of marriage was in this way obtained of 6,556 patients, or 82 per cent of all ever-married patients, the percentage being smaller for females (79) than for males (86). The difference between the sexes is due to the excess of widowed among women compared with men (women collectively marry earlier and live longer than men, and hence more are widowed). Marriages terminated by divorce or separation are also excluded.

	Ever-married	Married once and married at first attendance (enduring marriages)	Per cent b of a
	a	b	c
Males	3,388	2,914	86
Females ...	4,608	3,642	79
Total	7,996	6,556	82

Table 45. *Ever married patients compared with those married once and at first attendance* (*enduring marriages*).

6,556 in- and outpatient discharges.

The duration of these 6,556 marriages, which had proved stable (in the sense that they had not been terminated) up to the time the patient attended hospital, is shown in table 46. The durations vary according to the diagnostic group within the considerable span of over fifteen years: the shortest duration is a little less than nine years for females with pathological and immature personalities, and the longest is over thirty-seven years for females with senile psychoses.

Several factors contribute to the average duration of marriage as here shown. The most obvious is the average age of the patients in the group (the average age of partners in enduring marriages will

be shown in future reports; it is obviously higher than for all patients (including the single) as shown in table 40). Another factor is the average age at which the relevant patients in different groups marry. Another is the proportion within each group of broken marriages and the ages of patients at which their marriages break up. Thus the average duration of the enduring marriages of patients with pathological and immature personalities will appear relatively short if the relatively numerous marital casualties in this group (c.f. table 43) had occurred after long rather than short durations of marriage. In such circumstances the enduring (or surviving) marriages would be shorter than those of otherwise similar diagnostic groups wherein marriages had been more stable.

The following features of table 46 are noteworthy.

(1) The relatively short duration of marriage (9 years) for females with pathological and immature personalities—a duration which was 3 years shorter than that for women in any of the other fourteen groups. This difference probably is accountable by the fact that all women with anxiety (including the single) were nearly five years older than the others (table 40), and by the fact that the marital casualty rate of women with anxiety was less than a quarter that of the others (6·9 compared with 28·7 per cent of the ever-married: table 43).

(2) The shorter duration (by three years) of marriages of men with obsessive-compulsive reactions (9 years) compared with women similarly diagnosed (12 years). Again there was probably a congruous dissimilarity in the ages of men and women patients who were partners in enduring marriages, for among total discharges and irrespective of marital status, women diagnosed as showing obsessive compulsive reactions were over three years older than men. This difference between the sexes again suggests that obsessive compulsive reactions develop a severity warranting referral to a psychiatrist rather later in women than men.

(3) There is a conspicuous difference between the sexes (of eleven years) in the figures for paranoia and paranoid states. Though numbers are small, this disparity supports the view that paranoid symptoms may appear as a feature of the menopause, which is likely to begin about 21 years after marriage.

Diagnostic group	Males		Females	
	No.	Average duration of marriage (years)	No.	Average duration of marriage (years)
1. Pathological and immature personalities	207	9	103	9
2. Anxiety	415	12	513	12
3. Obsessive-compulsive reaction	78	9	84	12
4. Hysteria	85	14	195	13
5. Other psychoneuroses ...	270	12	295	14
6. Schizophrenic disorders ...	155	11	262	13
7. Neurotic - depressive reaction	375	18	748	15
8. Alcoholic and drug addictions	97	17	28	15
9. Manic-depressive reactions	377	23	536	21
10. Paranoia and paranoid states	42	15	36	26
11. Organic disorders of the C.N.S.	36	23	51	27
12. Other psychoses	128	30	183	27
13. Senile psychoses, etc. ...	68	36	49	37
14. Sexual deviations	76	11	0	—
Miscellaneous	302	17	351	14
Other groups within rubrics 300–325 each aggregating less than 75 patients ...	41	—	23	—
Total	2,752	—	3,457	—

Table 46. *Average duration of enduring marriage.*

6,209 in- and outpatients married at first attendance in sixteen groups. (Figures exclude divorced, widowed, separated and cohabiting patients).

8. Fertility: Number of Children Born Alive

This matter was dealt with on pages 65-67 of the first of these reports and in chapter two, section seven of this report. It was there shown that the average number of children born alive to ever-married males was 1·76 and to ever-married females 1·68, these being individuals counted once only during the triennium and not discharges which may be multiple for the same individual during the period. But many of the families were incomplete: of ever-married females 36 per cent, and of ever-married males 29·8 per cent were under thirty-five.

Table 47, which records discharges and not individuals, compares by diagnostic groups the average number of children born alive to 7,996 ever-married patients with the average durations of the enduring marriages of 6,209 patients. It shows that the number of children born alive ranges from 1·2 (among female obsessive-compulsives: duration of enduring marriages 12 years) to 3·1 (females with senile psychosis: duration of enduring marriages 37 years). The table also shows that there is a general but uneven correspondence between numbers of children and durations of marriage. The most conspicuous deviation is provided by the group of pathological and immature personalities (females) whose average duration of enduring marriage is the shortest of any group (9 years) but whose fertility ranks fifth on the list. These patients were younger that the hospital average (table 40. See remarks in chapter one, section five).

Diagnostic group	Males			Females		
	Numbers ever-married	Number of children born alive to ever-married men	Average duration of enduring marriages 2,752 men: (83% of total) Years	Numbers ever-married	Number of children born alive to ever-married women	Average duration of enduring marriages 3,457 women (76% of total) Years
1. Obsessive-compulsive reaction ...	86	1·3	9	103	1·2	12
2. Schizophrenic disorders	179	1·5	11	327	1·4	13
3. Hysteria	108	1·7	14	244	1·3	13
4. Alcoholic and drug addictions ...	134	1·8	17	46	1·3	15
5. Pathological and immature personalities	276	1·5	9	164	1·6	9
6. Anxiety	475	1·7	12	604	1·6	12
7. Other psychoneuroses	306	1·7	12	341	1·6	14
8. Neurotic depressive reaction ...	479	1·8	18	985	1·6	15
9. Organic disorders of the C.N.S. ...	41	1·7	23	73	1·8	27
10. Paranoia and paranoid states ...	50	1·9	15	55	1·9	26
11. Manic-depressive reaction	458	1·9	23	764	1·9	21
12. Other psychoses	150	2·3	30	270	2·1	27
13. Senile psychoses, etc.	88	2·6	38	116	3·1	37
14. Sexual deviations	88	1·5	11	1	—	—
Miscellaneous	369	1·7	17	431	1·7	14
Other groups within rubrics 300–325	48	—	—	30	—	—
Total	3,335	1·76	—	4,554	1·70	—

Table 47. Fertility and duration of marriage by diagnosis and sex.

Children born alive to 7,889 ever-married in- and outpatient discharges; and duration of marriage among 6,209 such discharges (78·7 per cent) whose first marriages were enduring at admission.

9. Previous Admissions to the Joint Hospital at any Time

In this section are considered previous admissions both to the wards and to the outpatient department. An admission to the wards is counted as such irrespective of the length of time that has elapsed since a previous discharge. An admission, or new admission, to the outpatient department is counted as such if a period of three months or more has elapsed since a patient's last attendance and if no appointment has been made for the patient to attend after three months. An admission (which covers a period) to the outpatient department thus differs from an attendance there, of which one or more may take place in the course of a single admission (see table 52).

The admission ratio, shown in tables 48, 49 and 50, expresses the number of admissions per hundred patients, counting the present admission as one. These three tables give an idea of the comparative persistence in their demands for help of patients in different diagnostic groups.

Table 48 is the most comprehensive in that it records all previous admissions, both to the wards and to the outpatient department, of all discharges from these two places which number 12,136 (there being four patients among the total of 12,140 of whom the relevant information was not available).

If the figures bracketed in the totals column, which are less than 100, are left out of account, it will be seen that the admission ratios range from 251 for manic-depressives (easily the most pertinacious of patients, the ratios being closely similar in the two sexes) to 137 for sexual deviations (easily the lowest ratio), of whom the great majority were males. Sexual deviations, among which homosexuality is well represented, differ from manic-depressive disorders in fluctuating little and being relatively unamenable to treatment; a single attendance, which commonly occurs when the patient is young (see table 40), may sometimes assist him to accept his abnormality and to make a social adjustment. Nearly 30 per cent of these patients lapse in their outpatient attendances (table 61).

High admission ratios (of 200 or over) are shown by patients with schizophrenia, obsessive compulsive reactions (higher for females than males), and alcoholic and drug addictions (higher for males than females). Low admission ratios (of 175 or under) are shown by female patients with senile psychoses, "other psychoneuroses" (the explanation of the low ratio for males is not obvious), pathological and immature personalities (males) and "miscellaneous" cases.

Admission ratios consolidated for all diagnostic groups are conspicuously higher for women than for men (198 against 184),

there being but three groups (wherein the totals exceed a hundred) in which they are higher for men; these are senile psychoses, organic diseases of the C.N.S., and alcoholic and drug addictions.

The above mentioned ratios for the consolidated totals of all groups (198 for females and 184 for males) are conspicuously larger than the corresponding figures for the first triennium (165 and 156 respectively: Cf. table 49 of first report). A possible cause of the difference is that the wards of the Maudsley hospital were closed and the outpatient department was being conducted on a smaller scale from 1939 to 1946 thus restricting the opportunity for previous admissions. On these grounds an increase in admission ratios could be expected in successive triennial reports until such time as the war years lose their importance.

Diagnostic group	Males			Females			Totals		
	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio
Schizophrenic disorders	634	1,293	204	654	1,435	219	1,288	2,728	212
Manic-depressive reaction	604	1,494	247	1,044	2,639	253	1,648	4,133	251
Paranoia and paranoid states	73	138	189	75	142	189	148	280	189
Senile psychoses, etc.	102	187	183	144	232	161	246	419	170
Organic disorders of the C.N.S. ...	53	100	189	94	160	170	147	260	177
Psychosis from epilepsy	14	27	193	12	25	208	(26	52	200)
Other psychoses	177	353	199	360	718	199	537	1,071	199
Anxiety	744	1,307	176	793	1,393	176	1,537	2,700	176
Hysteria	153	272	178	401	746	186	554	1,018	184
Obsessive-compulsive reaction	157	303	193	154	352	229	311	655	211
Neurotic depressive reaction	665	1,193	179	1,292	2,422	187	1,957	3,615	185
Other psychoneuroses	431	641	149	464	796	172	895	1,437	161
Pathological and immature personalities	627	1,027	164	338	628	186	965	1,655	172
Sexual deviations	247	330	134	15	28	187	262	358	137
Non-sexual delinquency or crime ...	56	98	175	27	44	163	(83	142	171)
Alcoholic and drug addiction	169	359	212	56	99	177	225	458	204
Primary childhood disorders	25	35	140	10	18	180	(35	53	151)
Mental deficiency	56	89	159	31	39	126	(87	128	147)
Miscellaneous	598	1,046	175	587	1,031	176	1,185	2,077	175
Total	5,585	10,292	184	6,551	12,947	198	12,136	23,239	191

Table 48. *Previous admission to wards or outpatients' department.*

Admission ratios of 12,136 in- and outpatient discharges in nineteen groups. (Totals under one hundred in brackets.)

Table 49 differs from 48 by taking into account admissions to the wards only. The admission ratios are therefore smaller than in the preceding table wherein are included admissions to the outpatient department as well as to the wards.

In the two tables the same two groups come first and last. In table 49 the group of manic-depressives (admission ratio for combined sexes 162) heads the list by as wide a relative margin as in table 48; and the same can be said about the group of sexual deviations which has much the lowest ratio of 105. Groups with high ratios of 135 and over are schizophrenia (143: figure higher for females than males), other psychoses (142), organic diseases of the C.N.S. (135), and obsessive-compulsive reaction (135: higher for females than males). Groups with low rates of 125 and under are "other psychoneuroses" (117), pathological and immature personalities (118), anxiety (120), and the miscellaneous group (126). For alcoholics and drug addicts the ratio for admissions to the wards (133: table 49) is relatively smaller than that for total admissions (204: table 48). These patients are carefully followed up. After a period in the wards some attend the outpatient department at long intervals to report on themselves, each attendance then being counted as a separate admission.

As in the preceding table, the overall ratio for women (135) is substantially higher than for men (128). No comparable figures are available for the first triennium.

Diagnostic group	Males			Females			Totals		
	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio
Schizophrenic disorders	634	871	137	654	977	149	1,288	1,848	143
Manic-depressive reactions	604	961	159	1,044	1,703	163	1,648	2,664	162
Paranoia and paranoid states	73	92	126	75	100	133	148	192	130
Senile psychoses, etc.	102	140	137	144	176	122	246	316	128
Organic disorders of the C.N.S.	53	72	136	94	126	134	147	198	135
Psychosis from epilepsy	14	19	136	12	15	125	(26	34	131)
Other psychoses	177	249	141	360	512	142	537	761	142
Anxiety	744	872	117	793	966	122	1,537	1,838	120
Hysteria	153	196	128	401	525	131	554	721	130
Obsessive-compulsive reaction	157	204	130	154	217	141	311	421	135
Neurotic depressive reaction	665	849	128	1,292	1,674	130	1,957	2,523	129
Other psychoneuroses	431	487	113	464	557	120	895	1,044	117
Pathological and immature personalities	627	724	115	338	418	124	965	1,142	118
Sexual deviations	247	258	104	15	17	113	262	275	105
Non-sexual delinquency or crime	56	63	112	27	32	119	(83	95	114)
Alcoholic and drug addiction	169	229	136	56	71	127	225	300	133
Primary childhood disorders	25	25	100	10	11	110	(35	36	103)
Mental deficiency	56	63	112	31	32	103	(87	95	109)
Miscellaneous	598	749	125	587	740	126	1,185	1,489	126
Totals	5,585	7,123	128	6,551	8,869	135	12,136	15,992	132

Table 49. *Previous admissions to wards.*

Admission ratios of 12,136 in- and outpatients in nineteen groups.
(Totals under one hundred in brackets.)

Table 50 differs from tables 48 and 49 in dealing with a smaller group. It is concerned with previous admissions *to the wards* of the 3,641 *inpatients* discharged from the wards. These figures may provide the most interesting series to the joint hospital's medical staff in that they give a rough idea of the probability of patients assigned to different diagnostic groups, who are admitted to the wards for the first time, being later readmitted as inpatients. The probability is rough because it is based on the assumption that future events will take the same course as past events, that, for example, there will be no substantial change in the clinical quality of candidates for admission to the wards, in the standards of admission adopted by the senior medical staff, and in the comparative efficiency of the treatment of different clinical and diagnostic groups such as might favour the admission of some and not of others.

Among the factors which today influence the probability of readmission are the recurrent nature of an illness, the benefits gained from treatment (which, if substantial, make readmission worth while), the need for continuous observation (as, for example, among young epileptics), and the value for teaching purposes of the case.

But assuming constancy in the relevant factors, the admission ratios here shown perforce give somewhat uncertain indices of the probability of readmission for the reason that there are counted into them multiple earlier admissions (in excess of one) of the same patient. (Compare the overall admission ratio of 126 (table 50) with the fact (table 18) that 17·6 per cent of inpatients had been inpatients before.) Another source of error (producing opposite effects but remediable by time) causing the admission ratio to provide an unduly low index of the probability of readmission is that the wards of the Maudsley hospital were closed during the years 1939-1946. (But outpatients were then seen and some of those needing admission to wards were taken into either Mill Hill or Sutton Emergency Hospitals.)

It will be seen from table 50 that, of ratios relating to totals of over fifty, manic depressive disorders again come easily first with a figure of 145, there being little difference between the sexes. Next comes the "miscellaneous" group (ratio 130: c.f. table 37 which shows the distribution of these cases among combined in- and outpatients). Many of these patients are epileptics who were readmitted for observation and retesting. Also high is the figure of 126 for schizophrenics and obsessive-compulsives, both of which groups have exactly the same ratios for each sex (124 for males and 129 for females).

Low ratios (for total figures) are those for alcoholic and drug addictions (the low figure of 109 could imply either that few alcoholic and drug addicts relapsed after treatment thus requiring readmission, or that the further treatment of relapsed cases was deemed unprofitable), and for senile psychoses (114). It is also perhaps worth noting, despite their small number, that none of the fourteen patients admitted during the triennium to the wards because of sexual deviations had been admitted before (ratio 100).

Diagnostic group	Males			Females			Totals		
	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio	Number of patients	No. of admissions	Admission ratio
Schizophrenic disorders	263	326	124	290	373	129	553	699	126
Manic-depressive reactions	271	381	141	441	649	147	712	1,030	145
Paranoia and paranoid states ...	28	32	114	24	29	121	52	61	117
Senile psychoses, etc.	41	49	120	42	46	110	83	95	114
Organic disorders of the C.N.S. ...	22	25	114	51	60	118	73	85	116
Psychosis from epilepsy	9	13	144	8	9	113	(17	22	129)
Other psychoses	96	112	117	143	179	125	239	291	122
Anxiety	108	121	112	142	177	125	250	298	119
Hysteria	52	55	106	125	153	122	177	208	118
Obsessive-compulsive reaction	46	57	124	34	44	129	80	101	126
Neurotic depressive reaction	203	240	118	362	424	117	565	664	118
Other psychoneuroses	71	78	110	105	124	118	176	202	115
Pathological and immature personalities	99	113	114	69	80	116	168	193	115
Sexual deviations	10	10	100	4	4	100	(14	14	100)
Non-sexual delinquency or crime ...	9	12	133	4	4	100	(13	16	123)
Alcoholic and drug addictions	59	66	112	19	19	100	78	85	109
Primary childhood disorders	4	5	125	6	8	133	(10	13	130)
Mental deficiency	7	8	114	1	1	100	(8	9	113)
Miscellaneous	174	240	138	199	245	123	373	485	130
Totals	1,572	1,943	124	2,069	2,628	127	3,641	4,571	126

Table 50. *Previous admission to wards of inpatients.*

Admission ratios of 3,641 inpatient discharges in nineteen groups.
(Figures relating to totals of under fifty are in brackets.)

10. Duration of Stay in Hospital: Inpatients

Average durations of stay of inpatients distributed by diagnostic groups are shown in table 51, and the periods are compared with those which obtained in the earlier triennium. The sexes are separately tabulated and the numbers of patients in each group are shown in brackets.

It will be seen that the average durations varied by more than three months from 5·5 months for male obsessive-compulsive neurotics to 2·4 months for males with alcoholic and drug addictions. The average stay for all groups was 3·6 months for males and 4·0 months for females—figures exactly similar to those for the earlier triennium.

Despite the fact that, for the two triennia, the consolidated figures yield a similar length of stay, the differences between diagnostic groups over the two periods are more pronounced than any comparable differences (between the same groups in the two triennia) shown in this chapter.

The duration of stay for male obsessive-compulsive neurotics, who easily head the list for males in the second triennium, is longer by 1·6 months than during the first period; the duration of stay of female schizophrenics is longer by 1·4 months (schizophrenia now ranking second instead of sixth on the female side of the list), and that of females with anxiety by 0·8 months. Further differences can be seen at a glance by comparing the figures in the two pairs of adjacent columns and by noting how far are the figures in the second column of each pair from occupying the descending order held by those in the first.

Males			Females		
Diagnostic group	Duration of stay (months)		Diagnostic group	Duration of stay (months)	
	52–54	49–51		52–54	49–51
1. Obsessive-compulsive reaction (46)	5·5	3·9	1. Obsessive-compulsive reaction (34)	5·4	4·7
2. Schizophrenic disorders (263)	4·2	4·6	2. Schizophrenic disorders (290)	5·1	3·7
3. Organic disorders of the C.N.S. (22) ...	4·1	3·4	3. Pathological and immature personalities (69)	4·2	4·0
4. Other psychoses (96)	4·0	4·0	4. Anxiety (142)	4·2	3·4
5. Manic-depressive reaction (271)	3·8	3·4	5. Manic-depressive reaction (441)	4·0	4·0
6. Senile psychoses, etc. (41)	3·6	3·1	6. Paranoia and paranoid state (24)	4·1	—
7. Pathological and immature personalities (99)	3·5	2·9	7. Senile psychoses, etc. (42)	3·9	3·9
8. Hysteria (52)	3·2	3·4	8. Organic disorders of the C.N.S. (51) ...	4·1	—
9. Other psychoneuroses (71)	3·3	2·8	9. Hysteria (125)	3·9	3·2
10. Anxiety (108)	3·1	3·4	10. Other psychoses (143)	3·9	4·5
11. Paranoia and paranoid states (28)	3·0	—	11. Other psychoneuroses (105)	3·8	—
12. Neurotic depressive reaction (203)	3·0	2·8	12. Neurotic depressive reaction (362)	3·3	3·1
13. Alcoholic and drug addictions (59)	2·4	2·0	13. Alcoholic and drug addictions (19)	2·8	1·8
Miscellaneous (174)	3·2	—	Miscellaneous (199)	3·7	—
Five groups of under ten (39)	—	—	Five groups of under ten (23)	—	—
Average stay	3·6	3·6	Average stay	4·0	4·0
Total 1,572			Total 2,069		

Table 51. *Duration of stay in months.*

3,641 inpatient discharges in fourteen groups.
(Numbers of patients in each group are in brackets.)

11. Number of Times Seen (Attendances): Outpatients

By an attendance is meant an interview with a doctor at the joint hospital in the course of a single admission (defined on p. xii). Interviews with psychologists and social workers are not here included.

The attendances of 8,449 outpatient discharges are shown in groups are separately arranged according to sex. The numbers comprised in each group are shown in brackets, and groups comprising less than thirty patients are excluded from the numbered lists, being shown at the bottom of the table.

It will be seen that the average frequencies ranged from 9·5 for male-obsessive-compulsives to 1·8 for mental defectives of both sexes; that the average frequency for all groups is substantially higher in the later compared with the earlier period; and that the consolidated figure for women (4·9) is larger than that for men (4·5) thus contrasting with events in the first period.

The more numerous attendances in the second triennium are mainly due to better arrangements for supportive clinics conducted by registrars and for recording attendances at group therapy sections.

Males			Females		
Diagnostic group	No. of times seen		Diagnostic group	No. of times seen	
	52–54	49–51		52–54	49–51
1. Obsessive-compulsive reaction (111)	9·5	7·5	1. Obsessive-compulsive reaction (120) ...	9·3	5·2
2. Sexual deviation (237)	7·8	5·7	2. Other psychoneuroses (359)	6·6	3·3
3. Other psychoneuroses (360)	6·0	4·0	3. Anxiety (651)	7·2	3·9
4. Anxiety (637)	5·9	3·8	4. Pathological and immature personalities (269)	5·4	3·7
5. Neurotic depressive reaction (462)	3·9	4·5	5. Hysteria (277)	4·9	3·5
6. Other psychoses (81)	3·7	—	6. Neurotic depressive reaction (930)	4·7	—
7. Manic-depressive reaction (333)	3·5	—	7. Other psychoses (217)	4·5	—
8. Paranoia and paranoid states (45)	3·5	—	8. Manic-depressive reaction (604)	3·8	3·8
9. Hysteria (101)	3·3	—	9. Alcoholic and drug addictions (37)	3·6	—
10. Pathological and immature personalities (528)	3·3	—	10. Schizophrenic disorders (364)	3·4	—
11. Schizophrenic disorders (371)	3·2	—	11. Paranoia and paranoid states (51)	2·6	—
12. Alcoholic and drug addictions (110)	3·0	—	12. Organic disorders of the C.N.S. (44) ...	2·1	—
13. Organic disorders of the C.N.S. (31) ...	2·8	—	13. Senile psychosis, etc. (102)	1·8	—
14. Senile psychosis, etc. (61)	2·4	—	14. Mental deficiency (30)	1·8	—
15. Non-sexual delinquency and crime (47) ...	2·3	3·9			
16. Mental deficiency (49)	1·8	—	(Primary childhood disorders) (4)	8·5	—
			(Sexual deviations) (11)	4·1	—
(Primary childhood disorders) (21)	3·4	—	(Psychosis from epilepsy) (4)	3·3	—
(Psychosis from epilepsy) (5)	1·9	—	(Non-sexual delinquency and crime) (23) ...	2·7	—
Miscellaneous (424)	3·6	—	Miscellaneous (388)	3·2	—
Total 4,014			Total 4,485		
Average for all groups	4·5	3·3	Average for all groups	4·9	3·0

Table 52. Number of times seen (attendances).

8,499 outpatient discharges in nineteen groups.
(Totals under thirty in brackets.)

12. Special Treatments: Inpatients

It was shown in chapter three (table 26) that the ten special treatments which are coded were given to a closely similar proportion of patients in the two periods—a little more than half.

The breakdown by diagnosis shows features which are generally similar to those of the first triennium.

Of 553 schizophrenics, 30 per cent were treated by electro-convulsive treatment (E.C.T.) and 35 per cent by deep insulin. Corresponding figures for the first triennium were 30 and 37 per cent.

Of 712 manic-depressive patients, 57 per cent were treated by E.C.T. compared with 63 per cent in the earlier triennium.

Of 78 alcoholics and drug-addicts, 49 per cent received special drug or other treatments, many by antabuse.

Of 239 patients with "other psychoses", 68 per cent were treated with E.C.T. compared with 72 per cent in the first triennium.

Of 565 neurotic depressives (203 males and 362 females), 31 per cent were treated with E.C.T. (28 per cent of the males and 33 per cent of the females).

The following are the percentages of patients treated by one or more of the ten methods enumerated in table 26 with the corresponding figures for the earlier triennium:

Diagnostic group	Per cent treated	
	1952-54	1949-51
Anxiety	34·4	31·0
Hysteria	35·0	29·0
Other psychoneuroses	38·1	32·1
Pathological and immature personalities	21·4	28·9
Senile psychoses	31·3	30·3

13. Outcome of Treatment

The outcome of treatment of inpatients is set out on a three-point scale in table 27: figures for each of the three years in the triennial period are shown and the consolidated totals for the period are compared with those of the first triennium.

Tables 53 and 54 are breakdowns by diagnosis. The first, which has no counterpart in the report on the first trennium, tabulates outcome by four major diagnostic assortments. Some interesting features emerge. The consolidated totals show that the results of

treatment are easily worst in the third assortment comprising disorders of character etc. If the miscellaneous group is excluded, there is recorded in this assortment the lowest percentage in the column headed *recovered or much improved* (29·9 per cent) and the highest percentage in that headed *no change, worse or died* (30·2 per cent). Indeed the number in this category is larger by one person than in the other. The outcome with males in this assortment is more variable than with females: more were assigned to the first and third categories in the table whereas more females than males—45·6 compared with 36·7 per cent—are recorded in the intermediate category as having improved or slightly improved.

The outcome among psychotics was likewise more variable than among psychoneurotics. In both sexes psychotics are better represented in the first and third categories (recovered or much improved and no change, worse or died) than psychoneurotics, the latter being more massed in the second, the difference (of twelve per cent) being most pronounced among females. The high recovery rate (56·1 per cent) among female psychotics is noteworthy. The favourable rates in the first column for psychotics compared with psychoneurotics are largely influenced by the excellence of the results of treatment in two groups of psychoses ("other psychoses" and manic-depressive reaction) discussed below. But they are also influenced by selection. The hospital favours the admission of cases deemed to be early and recoverable, however seriously ill, and its acute wards are adapted to the care of psychotic patients.

The outcome of treatment of the two sexes also differs. In comment on table 27 it was remarked that, in general, the outcome was somewhat better for women than men. It will be seen from table 53 that in all four diagnostic assortments relatively fewer women than men are recorded in the third column as having derived no benefit from treatment.

Diagnostic assortment	Recovered or much improved		Improved or slightly improved		No change, worse or died		No. of pat'nts
	No.	%	No.	%	No.	%	
Males							
Psychoses	368	50·4	184	25·2	178	24·4	730
Psychoneuroses ...	235	49·0	167	34·8	78	16·2	480
Disorders of character, etc.	57	30·3	69	36·7	62	33·0	188
Miscellaneous ...	45	25·9	67	38·5	62	35·6	174
Total	705	44·8	487	31·0	380	24·2	1,572
Females							
Psychoses	560	56·1	243	24·3	196	19·6	999
Psychoneuroses ...	387	50·4	281	36·6	100	13·0	768
Disorders of character, etc.	30	29·1	47	45·6	26	25·3	103
Miscellaneous ...	80	40·2	62	31·2	57	28·6	199
Total	1,057	51·1	633	30·6	379	18·3	2,069
Totals							
Psychoses	928	53·7	427	24·7	374	21·6	1,729
Psychoneuroses ...	622	49·8	448	35·9	178	14·3	1,248
Disorders of character, etc.	87	29·9	116	39·9	88	30·2	291
Miscellaneous ...	125	33·5	129	34·6	119	31·9	373
Total	1,762	48·4	1,120	30·8	759	20·8	3,641

Table 53. *Outcome of treatment.*

3,641 inpatient discharges in four major assortments.

Table 54 shows a more detailed distribution of inpatients by outcome of treatment. But the sexes are not separated, the numbers being too small. Figures relating to diagnostic groups wherein total patients do not exceed fifty are enclosed in brackets.

It is perhaps surprising that, in the assortment of psychoses, the group that is recorded as responding best to treatment is that of *other psychoses*, for which the figure of 70·3 per cent is the highest in the first category and that of 10·9 per cent the lowest in the third category. Next in order of successful response come manic depressives who, in the second triennium as in the first, form easily the largest group of inpatients (nearly a fifth: Cf. table 34). (In the first triennium, the ranking order of "other psychoses" and of manic-depressive reaction was the other way round; the latter responded better than any group to treatment.) It is the excellence of the results

of the treatment of these two psychoses (comprising 55 per cent of all psychotic inpatients (951 out of 1,729)) which is responsible for the generally favourable outcome of the treatment of psychoses as a whole.

It is to be expected that, of any group in the assortment of psychoses, that of senile psychoses should have the lowest figure in the first column and the highest in the third. But it may be of interest that the outcome for paranoid cases is worse than for schizophrenics in general. (In the first triennium this group was too small to count in.)

In the assortment of psychoneuroses, the large group of neurotic depressives easily comes out best. Next come patients with anxiety. The category of obsessive-compulsive neurosis—an intractable condition, but one to which patients can learn to adjust themselves—emerges as easily the least amenable to treatment. The figure in the third category is larger than that in the first: thirty per cent of cases failed to benefit at all. For some unexplained reason these results are worse than those recorded for this group in the first triennium when, of 99 cases, 39 per cent left hospital recovered or much improved and 21 per cent left unimproved.

In the third assortment comprising disorders of character, only two diagnostic groups contain more than fifty patients. Of these that comprising pathological and immature personalities comes out much the worst. Exactly a third leave without benefit—the same figure as for the first triennium—while definite improvement is recorded in but between a quarter and a fifth. Alcohol and drug addicts, on the other hand, responded better. Over a half recovered or were much improved and but 15 per cent derived no benefit. Some of these may have discharged themselves against advice. Figures are unfortunately not available for self-discharges for the second triennium, but during the first 18 per cent of alcoholic and drug addicts so discharged themselves.

In order to prevent misunderstanding among non-medical readers, it should perhaps be pointed out that the rather conspicuously favourable results obtained with manic-depressives (numerically the largest group of inpatients) can be misleading. These patients are liable to recurrent attacks. Though they leave hospital recovered and in good shape, other attacks calling for further admissions to hospital may be expected. It is shown (tables 48-50) that the readmission-rates (admission ratios) for manic-depressives were the highest of all diagnostic groups.

Diagnostic group	Total pat'nts	Recovered or much improved		Improved or slightly improved		No change, worse or died	
		No.	%	No.	%	No.	%
Schizophrenic disorders	553	200	36·2	172	31·1	181	32·7
Manic - depressive reaction	712	485	68·1	146	20·5	81	11·4
Paranoia and paranoid states	52	18	34·6	14	26·9	20	38·5
Senile psychoses ...	83	20	24·1	27	32·5	36	43·4
Organic disorders of the C.N.S.	73	30	41·1	15	20·5	28	38·4
Psychoses from epilepsy	(17	7	41·2	8	47·0	2	11·8)
Other psychoses ...	239	168	70·3	45	18·8	26	10·9
Anxiety	250	118	47·2	97	38·8	35	14·0
Hysteria	177	67	37·9	77	43·5	33	18·6
Obsessive-compulsive neuroses	80	19	23·7	37	46·3	24	30·0
Neurotic depression ...	565	359	63·5	161	28·5	45	8·0
Other psychoneuroses	176	59	33·5	76	43·2	41	23·3
Pathological and immature personalities	168	38	22·6	74	44·1	56	33·3
Sexual deviations ...	(14	1	7·1	7	50·0	6	42·9)
Non-sexual delinquency and crime	(13	2	15·4	2	15·4	9	69·2)
Alcoholic and drug addictions	78	40	51·3	26	33·3	12	15·4
Primary childhood disorders	(10	6	60·0	2	20·0	2	20·0)
Mental deficiency ...	(8	—	—	5	62·5	3	37·5)
Miscellaneous ...	373	125	33·5	129	34·6	119	31·9
Total	3,641	1,762	48·4	1,120	30·8	759	20·8

Table 54. *Outcome of treatment.*

3,641 inpatient discharges in nineteen groups.
(Figures relating to totals of under fifty are in brackets.)

14. Disposal

As in the earlier report, in- and outpatients are separately considered.

A. Inpatients for residential treatment elsewhere

It was shown in table 28 that, of 3,641 inpatient discharges, 304 (8·4 per cent) were, on leaving hospital, admitted to observation wards, mental hospitals and other hospitals other than psychiatric units and residential institutions.

Over a third (104) of these 304 disposals were of schizophrenics. The four diagnostic groups, comprising 1,082 patients, in which these disposals were most frequently made are shown in table 55. Of the 304 disposals to observation wards or hospitals, 185 were made from the 1,082 patients in these four groups (17·1 per cent).

Four diagnostic groups	Totals	Sent to observation wards or hospitals			
		Males (84)	Females (101)	Total	
				No.	%
Schizophrenia	553	18·6	19·0	104	18·8
Senile psychoses, etc. ...	83	7·3	31·0	16	19·3
Organic disorders of the C.N.S.	73	31·8	25·5	20	27·4
Miscellaneous	373	14·4	10·1	45	12·1
Total	1,082	16·8	17·4	185	17·1
All diagnostic groups ...	3,641	8·7	8·1	304	8·3

Table 55. *Disposal of inpatients.*

Percentages referred to observation wards, mental and other hospitals in four diagnostic groups. 3,641 inpatients.

B. Outpatients

Two features of the disposal of outpatients are, in a diagnostic breakdown, worthy of note. These are the admission rates to the joint hospital and the referrals to observation wards and mental hospitals.

(a) Outpatients admitted to joint hospital as inpatients

Admission of outpatients to the joint hospital's wards are shown by four major assortments in table 56 and in more detail in table 57.

Table 56 shows (totals column) that the admission rate for psychoneurotics (12·6 per cent) was somewhat under double that for patients with disorders of character (6·9 per cent), and that the rate for psychotics (24·6 per cent) was just under double that for psychoneurotics.

The figures for the second triennium differ in two main ways from those of the first (last two columns). A much smaller proportion of miscellaneous cases was admitted in the second compared with the first period (15·6 against 46·8 per cent); and the overall percentage of admissions to the wards was lower in the second triennium—15·2 compared with 22·6 per cent. Smaller percentages appear in

all three psychiatric assortments, the difference (of 4·8 per cent) being most pronounced in respect of the psychoneuroses which comprise nearly half of the total of 8,499 outpatients.

The admission to the wards of fewer miscellaneous cases in the second compared with the first period is partly accounted for by the fact that fewer such cases were seen in the outpatient department—9·6 compared with 12·7 per cent (Cf. table 32), and partly by an excess in the second period of patients showing no psychiatric abnormality (table 37).

The lower overall ratio of admissions of outpatients to the wards might also be in part attributable to a trend in the direction of less severe cases finding their way to the outpatient departments of psychiatric units and hospitals.

Diagnostic assortments and rubrics	Males			Females			Totals			
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	
									52-54	49-51
Psychoses (300–309) ...	927	235	25·4	1,386	333	24·0	2,313	568	24·6	27·8
Psychoneuroses (310–318)	1,671	186	11·1	2,337	320	13·7	4,008	506	12·6	17·4
Disorders of character, etc. (320–326) ...	992	59	5·9	374	35	9·4	1,366	94	6·9	9·5
Miscellaneous	424	65	15·3	388	62	16·0	812	127	15·6	46·8
Totals	4,014	545	13·6	4,485	750	16·7	8,499	1,295	15·2	22·6

(*a*) Total numbers.
(*b*) Numbers admitted to wards of joint hospital.
(*c*) Percentage admitted to wards of joint hospital.

Table 56. *Admissions to wards of joint hospital from* 8,499 *outpatient discharges in four major assortments.*

Table 57 shows that the admission rates to the wards during the second period were lower than those during the first in fifteen out of the sixteen diagnostic groups unenclosed in brackets, whose totals are less than seventy-five. The group which provides the exception is hysteria.

Among the sixteen groups, the admission rates vary from 29·5 per cent for manic depressives to 2·4 per cent for sexual deviants.

Diagnostic group	Males			Females			Totals			
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	
									52-54	49-51
Schizophrenic disorders	371	78	21·0	364	86	23·6	735	164	22·3	24·1
Manic-depressive reaction	333	103	30·9	604	173	28·6	937	276	29·5	32·1
Paranoia and paranoid states	45	8	17·8	51	15	29·4	96	23	24·0	25·0
Senile psychoses, etc.	61	12	19·7	102	9	8·8	163	21	12·9	17·3
Organic diseases of the C.N.S.	31	4	12·9	44	10	22·7	75	14	18·7	20·9
Psychosis from epilepsy	5	1	20·0	4	3	75·0	(9	4	44·4	41·6)
Other psychoses	81	29	35·8	217	37	17·1	298	66	22·1	30·1
Anxiety	637	48	7·5	651	58	8·9	1,288	106	8·2	12·8
Hysteria	101	15	14·9	277	51	18·4	378	66	17·5	14·7
Obsessive-compulsive reaction	111	18	16·2	120	13	10·8	231	31	13·4	26·1
Neurotic depressive reaction	462	82	17·7	930	162	17·4	1,392	244	17·5	24·6
Other psychoneuroses	360	23	6·4	359	36	10·0	719	59	8·2	10·0
Pathological and immature personalities	528	28	5·3	269	23	8·6	797	51	6·4	7·8
Sexual deviations	237	4	1·7	11	2	18·2	248	6	2·4	5·0
Non-sexual delinquency and crime	47	2	4·3	23	3	13·0	(70	5	7·1	1·5)
Alcoholic and drug addictions	110	22	20·0	37	7	18·9	147	29	19·7	36·6
Primary childhood disorders	21	1	4·8	4	—	—	(25	1	4·0	9·5)
Mental deficiency	49	2	4·1	30	—	—	79	2	2·5	—
Miscellaneous	424	65	15·3	388	62	16·0	812	127	15·6	46·8
Total	4,014	545	13·6	4,485	750	16·7	8,499	1,295	15·2	22·6

(*a*) Patients seen in the outpatient department
(*b*) Patients warded in joint hospital from outpatient department.
(*c*) Percentage warded of outpatients.

Table 57. *Admissions to wards of joint hospital from* 8,499 *outpatient discharges in nineteen groups.*

(Totals under seventy-five in brackets.)

(*b*) *Referrals—referrals of outpatients to observation wards and mental hospitals*

The general disposal of outpatients is shown in table 29. Of interest are the numbers referred to mental hospitals and observation wards. These are urgent cases which are either deemed unsuitable for admission to the wards of the joint hospital or for whom, at the time they are seen, no vacant beds in the hospital's acute wards are available. But some patients sent from the hospital to observation wards are later taken back into the joint hospital's wards.

It will be seen from table 58 that just over ten per cent of outpatients (10·3 per cent) were referred either to a mental hospital (6·6 per cent) or to an observation ward (3·7 per cent). Both figures are slightly larger than those for the earlier triennium (5·7 and 3·0 per cent respectively).

Admissions recommended to:	Males (4,014)		Females (4,485)		Totals (8,499)		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
Mental hospital ...	221	5·5	337	7·5	558	6·6	5·7
Observation ward ...	119	3·0	195	4·3	314	3·7	3·0
Totals	340	8·5	532	11·8	872	10·3	8·7

Table 58. *Disposal of* 8,499 *outpatients discharges.*

Admissions recommended to mental hospitals and observation wards.

Among patients distributed over the nineteen diagnostic groups, schizophrenics and manic-depressives were most frequently referred to those destinations. Within these groups are included nearly half the patients so referred—431 out of 872. It will be seen from table 59 that just under 30 per cent of schizophrenics and between a quarter and a fifth of manic-depressives were so referred. For schizophrenics the mental hospital was the destination rather more often than the observation ward (16·1 per cent against 13·6 per cent, though the balances differ between the two sexes); and for manic-depressives the mental hospital was the destination twice as often (15·0 against 7·7 per cent).

Diagnostic group	Males			Females			Totals				
	No.	Obs.	M.H.	No.	Obs.	M.H.	No.	Obs.	M.H.	Obs. + M.H.	
										52-54	49-51
Schizophrenia ...	371	10·5	18·1	364	16·8	14·0	735	13·6	16·1	29·7	25·9
Manic-depressive reaction	333	6·3	12·0	604	8·4	16·7	937	7·7	15·0	22·7	22·5

Obs. Percentage referred to observation ward.
M.H. Percentage referred to mental hospitals as voluntary patients.

Table 59. Disposal of 735 schizophrenic and of 937 manic-depressive outpatient discharges.

Percentages of these referred to observation wards and mental hospitals.

15. Mode of Leaving

Two features of the mode of leaving were considered in the first report—the self-discharge rate (discharges against advice) for inpatients and the lapse-rate for outpatients. Both in a measure can be treated as failures of treatment.

(*a*) *Inpatients discharging themselves against advice*

Self-discharge rates (percentages in each diagnostic group of patients who discharged themselves against advice) were shown in table 58 of the first report. The rates varied from a fifth (schizophrenics 21·1 per cent and pathological and immature personalities 20 per cent) to under a twelfth (8·2 per cent) among the group of "other psychoses". The overall figure for all inpatients was 13·8 per cent.

As mentioned above (page 38) the entries under the question about whether or not the patient had discharged himself against advice (which question was included in the front sheet of each patient's casenotes and answered throughout the period) was not coded and punched during the triennium. Hence trends in respect of this important feature of the hospital's activities cannot be shown. But the matter will be dealt with in the third of these reports covering the years 1955-1957.

(*b*) *Outpatients: lapses in attendance*

The mode of leaving of outpatients is set out in table 30 which shows that a little more than a fifth (20·8 per cent) of outpatients lapsed.

Breakdowns by diagnosis are shown in tables 60 and 61. It will be seen from table 60 that the lapse rate is higher for males than females in the first three assortments, and that the rate ranges from 17·4 per cent for female psychotics to 24·7 per cent (nearly a

quarter) for males with disorders of character. These differences are in general accordance with expectation. The overall lapse rate is a little higher in the second than in the first triennium, and the difference extends to three of the four assortments. Among patients with disorders of character, the lapse rate during the two periods is the same (23·1 per cent).

Diagnostic assortment	Males			Females			Totals			
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	
									52-54	49-51
Psychoses (300–309) ...	927	178	19·2	1,386	241	17·4	2,313	419	18·1	16·2
Psychoneuroses (310–318)	1,671	397	23·8	2,337	533	22·8	4,008	930	23·2	21·8
Disorder of character, etc. (320–326) ...	992	245	24·7	374	71	19·0	1,366	316	23·1	23·1
Miscellaneous	424	48	11·3	388	51	13·1	812	99	12·2	11·7
Total	4,014	868	21·6	4,485	896	20·0	8,499	1,764	20·8	19·3

(*a*) Number of outpatients.
(*b*) Number lapsed.
(*c*) Percentage lapsed.

Table 60. *Lapses in outpatient attendances.*

8,499 outpatient discharges grouped in four major assortments.

Table 61 shows the breakdown in greater detail: figures for totals under 75 are enclosed in brackets. If these are ignored, it will be seen that the highest lapse rates of 30 per cent and over occurred among males with paranoid states (33·3 per cent) and male alcoholic and drug addicts (31·8 per cent). Also high is the figure (28·7 per cent) for male sexual deviants. The lowest lapse rates (under 15 per cent) are found among mental defectives of both sexes (whose parents are commonly responsible for attendances) and among female senile psychotics (10·8 per cent). Differences between the sexes are most pronounced among paranoid patients, sexual deviants (the numbers for females being small), and alcoholic and drug addicts. In these three groups, the rates are higher for males than females. The group in which the rate is relatively highest for females is that of obsessive-compulsive reactions: but in the earlier triennium the lapse rate in this group was higher for males (23·4 against 19·1 per cent: not shown in table 61).

Between the two triennia the differences are most pronounced in respect of the group of paranoid states, senile psychotics and alcoholic and drug addicts, the lapse rates being in all three groups larger in the second than in the first period. The causes of these differences are not obvious.

Diagnostic group	Males			Females			Totals			
	(a)	(b)	(c)	(a)	(b)	(c)	(a)	(b)	(c)	
									52-54	49-51
Schizophrenic disorders...	371	66	17·8	364	69	19·0	735	135	18·4	19·7
Manic-depressive reaction	333	66	19·8	604	101	16·7	937	167	17·8	14·9
Paranoia and paranoid state	45	15	33·3	51	13	25·5	96	28	29·2	15·8
Senile psychoses, etc.	61	11	18·0	102	11	10·8	163	22	13·5	8·3
Organic disorders of the C.N.S.	31	7	22·6	44	8	18·2	75	15	20·0	18·6
Psychosis from epilepsy	5	—	—	4	—	—	(9	—	—	16·7)
Other psychoses	81	13	16·0	217	39	18·0	298	52	17·4	15·9
Anxiety	637	167	26·2	651	153	23·5	1,288	320	24·8	23·9
Hysteria	101	21	20·8	277	59	21·3	378	80	21·2	17·8
Obsessive-compulsive reaction	111	20	18·0	120	29	24·2	231	49	21·2	21·2
Neurotic depressive reaction	462	112	24·2	930	207	22·3	1,392	319	22·9	21·9
Other psycho-neuroses	360	77	21·4	359	85	23·7	719	162	22·5	20·2
Pathological and immature personalities	528	119	22·5	269	52	19·3	797	171	21·5	24·1
Sexual deviations	237	68	28·7	11	2	18·2	248	70	28·2	30·5
Non-sexual delinquency and crime	47	11	23·4	23	6	26·1	(70	17	24·3	15·9)
Alcoholic and drug addictions	110	35	31·8	37	8	21·6	147	43	29·3	20·6
Primary childhood disorders	21	8	38·1	4	2	50·0	(25	10	40·0	28·6)
Mental deficiency	49	4	8·2	30	1	3·3	79	5	6·3	10·5
Miscellaneous	424	48	11·3	388	51	13·1	812	99	12·2	11·7
Total	4,014	868	21·6	4,485	896	20·0	8,499	1,764	20·7	19·3

(*a*) Total patients.
(*b*) Number lapsed.
(*c*) Percentage lapsed.

Table 61. *Lapses in outpatient attendances.*

8,499 outpatient discharges in nineteen diagnostic groups.
(Figures relating to totals under seventy-five are in brackets.)

CHAPTER FIVE

CHILDREN

1. Introduction

Basic figures are shown in table 1. The figures for children differ from those for adults by being much smaller and by boys outnumbering girls.

The arrangement of this chapter follows that of chapters two and three. Sections 2-13 and tables 64 to 74 deal (as does chapter two in respect of adults) with 1,146 *individuals*. Sections 14-23 and tables 75 to 84 deal (as does chapter three) with 1,260 *discharges*, which are sometimes multiple for the same individual. It will be seen from table 62 that there were 114 such multiple discharges, 13 having been from the wards and 101 from the outpatient department.

A single table (84) shows diagnosis according to a simple six-point scheme based on the international classification which, in its entirety, is somewhat inappropriate for children. Another classification will be used in a future report.

	Number of individuals	Multiple discharges as			Total discharges
		In-patients	Out-patients	Total	
Boys	751	7	75	82	833
Girls	395	6	26	32	427
Total	1,146	13	101	114	1,260

Table 62. *Multiple discharges during the triennium.*

Table 63 compares the two triennia. It will be seen that, in the second, 65 fewer children were dealt with (1,146 compared with 1,211), and that the deficit lies wholly in the smaller number of girls (395 compared with 464), that of boys being closely similar in the two periods.

There was also a difference in the proportion of in- and outpatients over the two triennia. There were 50 more inpatients in the second period (40 more boys and ten more girls); but there were 115 fewer outpatients (846 compared with 961)—36 fewer boys and 79 fewer girls (table 63).

In respect of children, therefore, the trend of outpatients differs from that of adults. Among adults, more female than male outpatients were seen in the second period; among children, fewer.

The disturbances of boys, though more manifest than those of girls, are probably not more severe. But they attract more attention so that more boys than girls are referred.

The differences between in- and outpatients over the two periods have several causes. In the early years of the department the disturbances were more acute, many cases being referred by other outpatient clinics. Inpatient admissions reflect policy in respect of admission. The wards may be used for short term observation, for treatment over a longer or shorter period, or for the prolonged care of children for whom alternative provision is difficult to find.

Triennium	Boys			Girls			Total		
	I.Ps	O.Ps	Total	I.Ps	O.Ps	Total	I.Ps	O.Ps	Total
1949–51	153	594	747	97	367	464	250	961	1,211
1952–54	193	558	751	107	288	395	300	846	1,146
Ratio: 1949–51 =100	126	94	101	110	78	85	120	88	95

Table 63. *The two triennia compared: in- and outpatients by sex.*

2. Distribution by Age, Sex and Hospital Status

This is shown in tables 64, 65 and 66. It will be seen (table 66) that both boys and girls discharged during the second triennium were older than those discharged during the first. There were more aged 10-15 (58·7 compared with 54 per cent) and fewer who were under four (7·3 compared with 9 per cent).

During the second period as during the first, girls were somewhat older than boys; 63·8 compared with 56·1 per cent were aged 10 and over (table 66).

Girl inpatients were appreciably older than girl outpatients (75·7 compared with 59·4 per cent were aged ten and over); but among boys there was little difference in age between in- and outpatients (56·5 compared with 55·9 per cent being ten and over: table 64).

During the second triennium (table 65) inpatients of both sexes have been a little younger than during the first (63·4 per cent compared with 66·8 per cent were aged ten and over); but outpatients of both sexes have been older (57·1 per cent compared with 50·7 per cent over ten).

The tendency to admit younger inpatients in the second than in the first triennium is reflected in the numbers of children aged four

and under so admitted. Three times more were admitted in the second period than in the first—19 (6·3 per cent) compared with six (2·4 per cent c.f. table 65).

Two factors may affect the greater age of outpatients. At newly-established clinics the need to treat the young has been stressed; but there has been reluctance to undertake outpatient work with adolescents. The children's department has, moreover, been taking an interest in schizophrenia occurring in childhood; many of these patients (c.f. table 84) have been admitted and are in the two younger age groups. It will therefore be seen that, in the second triennium compared with the first, fewer total children (in- and outpatients combined) were dealt with, a pronounced deficit among outpatients masking a slight surplus among inpatients; and that outpatients were older and inpatients slightly younger.

Age group	Boys						Girls					
	Inpatients		Outpatients		1949–51		Inpatients		Outpatients		1949–51	
	No.	%	No.	%	I.Ps	O.Ps	No.	%	No.	%	I.Ps	O.Ps
0–4 ...	14	7·2	42	7·5	2·6	10·6	5	4·7	22	7·6	2·1	10·9
5–9 ...	70	36·3	204	36·6	37·9	39·9	21	19·6	95	33·0	19·6	36·5
10–15 ...	109	56·5	312	55·9	59·5	49·5	81	75·7	171	59·4	78·3	52·6
Total ...	193	100·0	558	100·0	100·0	100·0	107	100·0	288	100·0	100·0	100·0

Table 64. *Age by sex.*

1,146 children. In- and outpatients separately shown.

Age group	Inpatients both sexes			Outpatients both sexes		
	No.	Per cent		No.	Per cent	
		1952–54	1949–51		1952–54	1949–51
0–4	19	6·3	2·4	64	7·6	10·7
5–9	91	30·3	30·8	299	35·3	38·6
10–15	190	63·4	66·8	483	57·1	50·7
Total	300	100·0	100·0	846	100·0	100·0

Table 65. *Age by hospital status.*

1,146 children. In- and outpatients compared.

Age group	Boys			Girls			Total		
	No.	Per cent		No.	Per cent		No.	Per cent	
		52-54	49-51		52-54	49-51		52-54	49-51
0–4 ...	56	7·4	9·0	27	6·8	9·1	83	7·3	9·0
5–9 ...	274	36·5	39·5	116	29·4	33·0	390	34·0	37·0
10–15	421	56·1	51·5	252	63·8	57·9	673	58·7	54·0
Total ...	751	100		395	100		1,146	100	

Table 66. *Age by sex.*

1,146 children.
Triennial totals compared.

3. Marital Status of Parents

The distribution is given in table 67. It will be seen that, of 1,143 mothers whose marital status was known, 37 (3·2 per cent) were single. There remain 1,106 who had been married. Of these, the marriages of 170 (items 3-7 in table 67) had been terminated (15·4 per cent). The proportion of terminated marriages among married parents is a little higher for girls than boys (17·4 compared with 14·3 per cent), the main difference being among the divorced. This difference may be in part due to the fact that, in the sample, girls were on average older than boys; hence their parents had probably been married longer, thus giving more time for the marriage to disrupt.

There is little difference of note between the two triennia except that, contrary to what some might have expected (the provision of legal aid having facilitated the divorce of impecunious people who were chronically estranged and separated), the percentage of mothers divorced is slightly lower in the second period than in the first.

It was known of 1,064 children whether or not either of their parents had or had not been married more than once. Eighty-nine children (8·4 per cent) had a parent who had been married more than once. The proportion was a little higher (11·2 per cent) among girls than boys (6·9 per cent). Again the higher age of girls may partly account for this difference.

Marital status of parents	Boys		Girls		Totals		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
1. Single	25	3·3	12	3·1	37	3·2	2·1
2. Married	624	82·9	312	80·0	936	81·9	83·3
3. Widowed	32	4·3	15	3·8	47	4·1	4·7
4. Separated (judicially) ...	4	0·5	5	1·3	9	0·8	1·5
5. Separated (non-judicially) ...	37	4·9	22	5·6	59	5·2	3·8
6. Divorced	16	2·1	19	4·9	35	3·1	3·5
7. Cohabiting ...	15	2·0	5	1·3	20	1·7	1·1
Total known	753	100·0	390	100·0	1,143	100·0	100·0
Not known	13	—	10	—	23	—	—
Total statuses	766	—	400	—	1,166	—	—
Total patients	751	—	395	—	1,146	—	—

Table 67. *Marital status of parents of* 1,146 *children by sex of children.*

In- and outpatients combined.

4. Religions of Children

The distribution is shown in table 68. In the first of these reports a comment was made on the larger proportion of non-conformists among adult patients than among the parents of children (6·4 compared with 1·1 per cent). The difference for the second triennium is less pronounced (6·5 per cent for adults compared with 4·4 per cent for children). Again the proportion of Roman Catholics both among adults (11·6 per cent) and children (11·6 per cent) is larger than for the general population (seven per cent according to the Catholic Year Book). It is uncertain whether the disparity is caused by a local excess of Roman Catholics living in the areas of South London from which most of the hospital's patients come, or by a different incidence of psychiatric disturbance. Irish and Poles are numbered among hospital patients. Both (Poles especially) have difficulties of adjustment unknown to native Londoners. Table 68 is based on the religious faiths in which the children were being brought up and not of those of their parents (which may differ) as was the corresponding table (no. 64) in the first of these reports. It is for this reason that the percentages for the triennium 1949-51 exceed a hundred.

	Boys		Girls		Total		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
Church of England ...	553	79·0	295	79·5	848	79·2	80·8
Roman Catholic ...	86	12·3	39	10·5	125	11·6	12·6
Nonconformist ...	26	3·7	21	5·7	47	4·4	1·1
Jewish	16	2·3	7	1·9	23	2·1	2·6
Other	14	2·0	7	1·9	21	2·0	4·6
None	5	0·7	2	0·5	7	0·7	
Total known ...	700	100·0	371	100·0	1,071	100·0	—
Not known	51	—	24	—	75	—	—
Total	751	—	395	—	1,146	—	—

Table 68. *Religious up-bringing of children.*

1,146 in- and outpatients.

5. Weekly Income of Parents

The distribution is shown in table 69, from which it will be seen that information from over a third (36·6 per cent) was not available. Comparison with table 14 shows that the parents of the 727 "known" children are better off than adult patients, which is to be expected seeing that the latter include single and young patients, some of whose earnings are low. The most noteworthy feature of table 69, however, is the more favourable financial position of parents in the second, compared with the first, triennium. Relatively more than twice as many parents had gross incomes of more than £12 a week, and 85 per cent had incomes of over £7 a week, compared with under 51 per cent in the first period. There is still less suggestion than in the first triennium that the children were living in conditions of abnormal poverty.

	Usual weekly income (gross)												
	Over £12		£8–£12		£4–£7		Under £4		Total known		Not known		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Boys ...	105	21·7	305	63·0	72	14·9	2	0·4	484	100·0	267	35·6	751
Girls ...	56	23·0	152	62·6	35	14·4	–	–	243	100·0	152	38·5	395
Totals 1952–54	161	22·1	457	62·9	107	14·7	2	0·3	727	100·0	419	36·6	1,146
1949–51	84	10·5	316	39·9	377	47·1	20	2·5	797	100·0	414	34·2	1,211

Table 69. *Usual weekly income (gross) of parents of* 1,146 *children (in- and outpatients combined).*

6. Social Class

The distribution is shown in table 70. The distribution differs little from that of table 13 which gives the social class of adult patients. The percentage in classes 3, 4 and 5 are almost exactly the same. Unlike the figures for the first triennium (first report table 66) inpatients are better represented than outpatients in classes one and two; and the same can be said for the totals for the second triennium compared with the first, though the representation in classes 4 and 5 is also slightly higher.

	Class 1		Class 2		Class 3		Class 4		Class 5		Total known		Not known	Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%		
Inpatients														
Boys	21	10·0	28	13·3	117	55·7	18	8·6	26	12·4	210	100	14	224
Girls	8	8·2	23	23·5	51	52·0	9	9·2	7	7·1	98	100	9	107
Total inpatients ...	29	9·4	51	16·6	168	54·5	27	8·8	33	10·7	308	100	23	331
Outpatients														
Boys	23	4·9	50	10·6	266	56·4	78	16·5	55	11·6	472	100	55	527
Girls	10	3·9	40	15·6	139	54·1	41	15·9	27	10·5	257	100	31	288
Total outpatients ...	33	4·5	90	12·3	405	55·6	119	16·3	82	11·3	729	100	86	815
In- and outpatients: totals														
Boys	44	6·5	78	11·4	383	56·1	96	14·1	81	11·9	682	100	69	751
Girls	18	5·1	63	17·7	190	53·5	50	14·1	34	9·6	355	100	40	395
Total: boys and girls														
1952–54	62	6·0	141	13·6	573	55·2	146	14·1	115	11·1	1,037	100	109	1,146
1949–51	44	3·9	144	12·7	666	58·8	157	13·9	122	10·7	1,133	100	78	1,211

Table 70. Social class of parents by sex of children.

1,146 children. In- and outpatients separately shown.

7. Ages of Mothers at First Marriages and at Births of Children

The two distributions shown in table 71 are generally similar to those for the first triennium. But there is a suggestion that the mothers were a little older when the patients of the second compared with the first period were born, the percentages relating to the three age groups under thirty being smaller for the second triennium than the first, and those in the four higher age-groups (over thirty) being larger.

The age of a mother at the birth of a child is related to the child's birth order; the higher the birth order the older the mother is likely to be. It is hoped to include information on birth order in future reports.

The average age at marriage of 616 of the 1,146 mothers (a 54 per cent sample) was not unduly low. The figure of 23·4 years is similar to that for adult patients (24·0 years; Cf. table 9).

Age of mother	Mother's age at first marriage			Mother's age at birth of patient		
	No. of mothers	Per cent		No. of mothers	Per cent	
		52-54	49-51		52-54	49-51
Under 20 ...	116	18·9	21·3	28	2·8	4·3
20–24	298	48·4	49·3	282	28·4	29·5
25–29	151	24·5	21·8	314	31·7	32·1
30–34	42	6·8	6·1	218	22·0	19·8
35–39	7	1·1	1·4	110	11·1	10·5
40–44	2	0·3	—	36	3·6	3·5
45+	—	—	0·1	4	0·4	0·3
Total known ...	616	100·0	100·0	992	100·0	100·0
Unmarried ...	37					
Relevant age not known ...	493	43·0 (of total)		154	13·4 (of total)	
Total	1,146			1,146		
Average age at relevant time	23·4			28·2		

Table 71. *Ages of mothers at first marriage* (616 *mothers*) *and at birth of patients* (992 *mothers*).

8. Numbers of Children Born to Patients' Mothers

It will be seen from table 72 that the size of the average patient's sibship was slightly smaller in the second triennium than in the first. The figure (the patient being included in the sibship) was 2·86 for the second period and 2·93 for the first.

Table 73 shows that, in the second period, more children belonged to sibships of two (themselves having a single sib) than in the first (36 compared with 32·7 per cent); and that fewer belonged to large

sibships of five and over (14 compared with 18·1 per cent). Over fifty per cent of the first period's children belonged to sibships of three and over. The fact that the children dealt with in the second triennium were a little older than those pertaining to the first suggests that the comparative fertility of the mothers of the second triennium's children was in reality lower than is implied by the figures here given.

Reasons were submitted in the first of these reports for supposing that, after the Greenwood-Yule corrections and the youthfulness of many of the mothers had been taken into account, the hospital children's sibships were somewhat larger than the average for London. The conclusion was based on a comparison with figures yielded by the 1951 census. But this census provides a less reliable standard for comparison with the period 1952-54 than with that of 1949-51. Nevertheless the distribution of greater London families by size of sibship shown in table 73 does not suggest that the sibships to which the hospital's child patients belong were, in 1952-54, smaller than the London average.

Age of patient	Number of children (including patient) of patient's mother alive during triennium	
	1952–54	1949–51
0–4	2·3	2·1
5–9	2·7	2·7
10–15	3·0	3·1
Average size of family ...	2·86	2·93

Table 72. Fertility of children's mothers. Size of patient's sibship (alive 1952-54) by age of patient.

1,088 in- and outpatients.

Number of children per family	Number of patient's mother's children (including patient) alive (size of sibship)		
	1952–54		1949–51
	No. of children	Per cent of families	Per cent of families
One (patient only child) ...	192	17·6	17·0
Two	784	36·0	32·7
Three–four	1177	32·4	32·1
Five+	961	14·0	18·1

Table 73. Fertility of children's mothers.

Distribution by number of children (including the patient) in the family.
1,088 in- and outpatients.

9. Patients who are Twins

Of the 1,146 children (in- and outpatients combined) information as to whether or not they were twins was not available for fifteen. (The sample contains adopted children of whose parentage nothing is known.) Of the 1,131 children in respect of whom the information was available twenty-five (2·2 per cent) were twins. These were distributed as follows:

Sex of twin not known ...	5
Twin same sex	12
Twin different sex ...	8

10. Patients whose Parents are First Cousins

Relevant information was available for the parents of 1,028 of the 1,146 children. Of these seven (0·7 per cent) had parents who were first cousins.

11. Step- or Foster Mother Responsible for Child

Relevant information was available for 1,141 of the 1,146 children. Of these 152 (13·3 per cent) were in the care of step- or foster mothers. This figure is closely similar to that for the first triennium (13·4 per cent).

12. Previous Admissions

It will be seen from table 74 that, of 300 inpatients, 27 (9·0 per cent) had been previously admitted to the wards and that 155 (51·7 per cent) had previously been admitted to the outpatient department.

A quarter (24·3 per cent) of inpatients were referred by the outpatient department (Cf. table 75) to which the child may have been sent either for treatment or assessment.

Of 846 outpatients, ten only (1·6 per cent) had previously been admitted to the wards, but 91 (10·7 per cent) had been admitted before to the outpatient department. Of these one, a boy, had been so admitted four times. Indeed, of the nine outpatients who had previously been admitted more than once to the outpatient department, all were boys.

	Previous admissions as inpatient						Previous admissions as outpatient										Total children
	0		1		2		0		1		2		3		4		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Inpatients																	
Boys	175	90·7	18	9·3			86	44·6	100	51·8	6	3·1	1	0·5			193
Girls	98	91·6	7	6·5	2	1·9	59	55·2	46	43·0	1	0·93	1	0·9			107
Total inpatients	273	91·0	25	8·3	2	0·7	145	48·3	146	48·7	7	2·3	2	0·7	0		300
Outpatients																	
Boys	551	98·7	7	1·3			496	88·9	53	9·5	7	1·2	1	0·2	1	0·2	558
Girls	285	99·0	3	1·0			259	89·9	29	10·1							288
Total outpatients	836	98·8	10	1·2	0		755	89·3	82	9·7	7	0·8	1	0·1	1	0·1	846
Total in- and outpatients ...	1,109	96·8	35	3·0	2	0·2	900	78·5	228	19·9	14	1·2	3	0·3	1	0·1	1,146

Table 74. *Previous admissions at any time to wards or outpatient department of* 1,146 *in- and outpatients.*

13. Relatives of Children Treated at Joint Hospital

Of the total of 1,146 children, information was not available of 69. Of the remaining 1,077, 104 (9·7 per cent) had relatives (namely parents, uncles and aunts, grandparents, sibs and first cousins) treated at the joint hospital. Of 1,109 children as to whom the information was available, 45 (4·1 per cent) had sibs who had been treated in the children's department.

These figures are rather smaller than the corresponding figures for the first triennium, namely 12·6 per cent for relatives and 8·1 per cent for sibs. The smaller figures for the later period may be connected with the fact that the Children's department has been extending its catchment area. The smaller such an area and the fewer the hospitals in it, the larger the number of inter-related persons among its patients.

The remaining sections and tables of this chapter deal with discharges, sometimes multiple for the same individual.

14. Referring Agencies: Inpatients

Table 75 gives the distribution of agencies which referred ten or more children. The agencies are arranged in a descending order of the number of children they referred as shown in the totals column. There were 82 multiple referrals. Hence the percentages exceed a hundred. The thirty-two children alluded to in item 12 were referred by the following agencies (the number of children by each is in brackets): Consultant psychiatrists not on the joint hospital staff (9), the joint hospital's domiciliary service (4), joint hospital's children's department (4), Government departments (2), observation wards (2), other voluntary organisations (5), other sources (6).

Some conspicuous differences will be noticed between the two triennia. In the earlier period, more than half of the children (56·0 per cent) were referred by and admitted through the outpatient department; in the later, less than a quarter (24·3 per cent). There has been an associated increase in the proportions of all other referrals. It is noteworthy that the percentages of cases referred by other child guidance units (first in frequency on the list for the second period) and by psychiatric units or departments of general hospitals (third on the list) have more than doubled. These cases contributed less than a fifth (19·7 per cent) of the total in the first period; in the second they contributed nearly a half (48·9 per cent). Of cases referred by psychiatric departments of general hospitals, sixty-six were admitted directly, by-passing the outpatients department (table 75 item 3), and eighty were dealt with in the outpatient department (table 76 item 6). Children coming from other child guidance units and from the psychiatric departments of general hospitals are mostly difficult cases, and it seems that more of these were dealt with in the second than in the first triennium, thus slowing down the turn-over.

Referring agency	Boys		Girls		Total		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
1. Child guidance units outside	53	26·5	34	30·1	87	27·8	10·5
2. Outpatient department	55	27·5	21	18·6	76	24·3	56·0
3. Psychiatric unit or department of general hospital ...	38	19·0	28	24·8	66	21·1	9·2
4. Private doctor ...	15	7·5	13	11·5	28	8·9	2·5
5. General hospital (non-psychiatric)... ...	14	7·0	7	6·2	21	6·7	5·3
6. Probation service, remand home, etc.	15	7·5	6	5·3	21	6·7	1·1
7. Parents or spontaneous	13	6·5	4	3·5	17	5·4	1·8
8. Local education authority	12	6·0	3	2·7	15	4·8	1·8
9. Mental hospital ...	8	4·0	4	3·5	12	3·8	0·7
10. Consultant B/M staff	8	4·0	2	1·8	10	3·2	0·7
11. L.C.C. Case Committee	6	3·0	4	3·5	10	3·2	1·1
12. Remainder (see text)...	23	11·5	9	8·0	32	10·2	9·5
Total referrals	260	—	135	—	395	—	—
Total patients	200	—	113	—	313	—	9·5

Table 75. *Referring agencies by sex of children.*

313 inpatient discharges.

15. Referring Agencies: Outpatients

Table 76 gives the agencies which referred over 30 children each in a descending order of the total figures. There were 94 multiple referrals among the 947 children discharged. Hence the percentages exceed a hundred.

The 50 children recorded against item 11 were referred by the following agencies, the number of children referred being shown in brackets: domiciliary service (12), mental hospitals (11), government departments (8), consultant on joint hospital staff (7), consultant not on joint hospital staff (7), observation ward (1) and other sources (4).

The two triennia are not easily compared because of a wider range of referring agencies in the first. Item 11 shows that the number of cases referred by other agencies than the ten that are named in the table is three times larger for the first period (16·8 per cent of the total) than in the second (5·3 per cent). The most conspicuous differences between the two periods are the larger proportion of

cases referred by private doctors in the second period (31 compared with 24·9 per cent: item 1), and the smaller proportion (exactly half) referred by general hospitals (item 8).

The conspicuous difference in item 4 may be partly artificial. Some of the cases included in the large figure of 8·7 per cent for the second period were, during the first, probably distributed under miscellaneous headings, which were condensed in item 11. But the higher figure for self-referrals in the second period supports the view that the joint hospital's children's department is becoming better known to parents.

Referring agency	Boys		Girls		Total		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
1. Private doctor ...	187	29·5	107	34·1	294	31·0	24·9
2. L.C.C. Children s Committee ...	81	12·8	43	13·7	124	13·1	16·3
3. Probation service remand home, etc.	97	15·3	22	7·0	119	12·6	10·4
4. Parents and spontaneous ...	51	8·1	31	9·9	82	8·7	0·6
5. Ex-inpatients ...	52	8·2	29	9·2	81	8·6	3·7
6. Psychiatric unit or department of general hospital ...	54	8·5	26	8·3	80	8·4	5·6
7. Child guidance unit...	53	8·4	22	7·0	75	7·9	5·2
8. General hospital (non-psychiatric)	35	5·5	18	5·7	53	5·6	11·2
9. Local education authority (other than L.C.C.) ...	32	5·1	20	6·4	52	5·5	3·5
10. Other voluntary organisations ...	20	3·2	11	3·5	31	3·3	2·1
11. Remainder (see text)	31	4·9	19	6·1	50	5·3	15·9
Total referrals	693	—	348	—	1,041	—	16·8
Total patients	633	—	314	—	947	—	—

Table 76. *Referring agencies by sex of children.*

947 outpatient discharges.

16. Duration of Stay: Inpatients

It will be seen from table 77 that the mean stay over the triennium was just under six and a half months (6·4 months), and that there was little difference between the sexes.

As the triennium progressed the length of stay diminished being some six weeks shorter in 1954 (five and a half months) than in

1952 (seven months). Over the three years, 131 of the 313 children (41·8 per cent) stayed in for six months or longer. Forty-two children (13·4 per cent: 29 boys and 13 girls) stayed longer than a year: and forty-nine children (15·7 per cent), among whom again boys were better represented than girls, stayed for the short period of a month or less.

Over the six years of the two triennia, the duration of stay lengthened from under three months in 1949 to a peak length of seven months in 1952, after which it shortened for boys and, rather drastically, did the same in the last year for girls after a further rise to 7·4 months in 1953.

In the second triennium as a whole, the average length of stay (6·4 months) was about seven weeks longer than in the first (4·6 months). An explanation of these differences is offered in section 19 below (outcome of treatment).

	1 mth or less	2 mths	3 mths	4–5 mths	6–8 mths	9–12 mths	1 year or more	Mean mths	Total children
Boys									
1952	7	5	11	17	9	9	11	7·0	69
1953	8	10	13	10	13	3	12	6·5	69
1954	19	3	8	9	8	9	6	5·5	62
1952-54	34	18	32	36	30	21	29	6·4	200
Girls									
1952	4	4	4	4	6	4	4	7·0	30
1953	3	2	6	8	3	8	5	7·4	35
1954	8	8	5	6	12	5	4	5·6	48
1952-54	15	14	15	18	21	17	13	6·5	113
Total Both sexes	49	32	47	54	51	38	42	6·4	313
Per cent	15·7	10·2	15·0	17·3	16·3	12·1	13·4	—	100

Table 77. *Duration of stay by years* 1952, 1953 *and* 1954.

313 inpatients (discharges).

17. Numbers of Times Seen: Outpatients

The distribution is shown in table 78 from which it will be seen that though the average attendance over the two triennia is similar (between seven and eight attendances per child) the distribution is somewhat different. There were more children discharged after one

or two attendances in the second period than the first (42·5 compared with 37·3 per cent) and more were also discharged after numerous (over 25) attendances (8·6 against 4·7 per cent). In respect of all except one of the other seven categories, the percentages are higher for the first than the second period.

The excess in the second period of children who were discharged after a single attendance is in part due to the fact that the children's department is increasingly used for consultation by other and more distant child psychiatric clinics.

But the fact that the average number of attendances is sustained implies that much continuous treatment is being carried out.

Number of times seen	Boys		Girls		Total		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
One	205	32·4	97	30·9	302	31·9	27·7
Two	57	9·0	43	13·7	100	10·6	9·6
Three	39	6·2	20	6·4	59	6·2	6·8
Four	32	5·1	14	4·5	46	4·9	6·0
5–6	72	11·4	30	9·5	102	10·8	9·4
7–9	47	7·4	33	10·5	80	8·4	11·8
10–12	45	7·1	19	6·0	64	6·8	8·8
13–18	51	8·0	18	5·7	69	7·3	10·2
19–25	29	4·6	14	4·5	43	4·5	5·0
26+	56	8·8	26	8·3	82	8·6	4·7
Total	633	100·0	314	100·0	947	100·0	100·0
Average 1952–54...	7·8		7·3			7·7	7·6
1949–51...	8·0		7·3				

Table 78. *Number of times seen by sex of children.*

947 outpatient discharges.

18. Special Investigations: Inpatients

The distribution given in table 79 is generally similar to that for the first triennium upon which some comments were made in the first of these reports. More investigations were made in the second than in the first period because there were more inpatients (313 compared with 284). The average number of investigations per child was over four in both periods.

Type of investigation	Boys		Girls		Totals		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
A. Physical Tests							
Electroencephalogram	153	76·5	86	76·1	239	76·4	71·8
X-rays	79	39·5	42	37·2	121	38·7	25·0
Blood count	48	24·0	43	38·1	91	29·1	20·1
Erythrocyte sedimentation	38	19·0	25	22·1	63	20·1	19·4
Wasserman or Kahn ...	36	18·0	24	21·2	60	19·2	21·5
Bacteriological tests ...	21	10·5	6	5·3	27	8·6	6·0
Cerebro-spinal fluid ...	10	5·0	7	6·2	17	5·4	2·8
Electrocardiogram ...	2	1·0	2	1·8	4	1·3	4·2
Glucose tolerance and insulin	3	1·5	—	—	3	1·0	3·2
Basal metabolic rate	1	0·5	1	0·9	2	0·6	2·5
Biopsy	—	—	1	0·9	1	0·3	0·7
Other special biochemical tests ...	45	22·5	22	19·5	67	21·4	15·1
Other microscopical tests	10	5·0	3	2·7	13	4·2	2·1
Other somatic investigations	3	1·5	5	4·4	8	2·6	4·6
Other immunity tests	5	2·5	—	—	5	1·6	1·8
Total	454	—	267	—	721	—	—
B. Psychological tests							
Verbal intelligence tests	148	74·0	86	76·1	234	74·8	71·2
Non-verbal intelligence tests	141	70·5	84	74·3	225	71·9	68·0
Projection tests ...	58	29·0	25	22·1	83	26·5	18·3
Educational tests ...	33	16·5	7	6·2	40	12·8	—
Tests of deterioration	6	3·0	3	2·7	9	2·9	4·6
Differential aptitude tests	2	1·0	2	1·8	4	1·3	3·5
Other special psychological tests ...	17	8·5	6	5·3	23	7·3	15·1
Total	405	—	213	—	618	—	—
C. Other procedures							
Specialist opinion ...	39	19·5	23	20·4	62	19·8	27·1
Total tests and opinions	898	—	503	—	1,401	—	1,159
Total children ...	200	—	113	—	313	—	284
Number of tests and opinions per child ...	—	—	—	—	—	4·48	4·1

Table 79. Special investigations by sex of children.

313 inpatient discharges.

19. Outcome of Treatment

Table 80 compares the three years of the triennium with one another, and the triennial totals with those of the earlier period. It will be seen that the outcome of the treatment of inpatients was recorded as increasingly unfavourable as time passed. In 1954 proportionately less than half the children were discharged recovered or much improved as were so discharged in 1952 (20·9 compared with 42·4 per cent); and in 1954 over a third (34·5 per cent) were discharged without benefit compared with under a fifth (19·2 per cent) in 1952.

If the two triennia are compared, it will be seen that over five per cent fewer children were discharged in the second than in the first period as having recovered or much improved.

These differences reflect the department's practice of setting aside two beds for a diagnostic investigation of two weeks, after which the patient was usually discharged. They are also affected by the department's study of schizophrenic children. The outcome (table 80) and the duration of stay (table 77) are both biased by this study: the figure for children discharged as not improved after two weeks investigation and stay in the unit is raised, as is that for long-stay inpatients (duration of stay a year or more).

Year	Outcome of treatment*	Boys		Girls		Totals		
		No.	%	No.	%	No.	Per cent	
1952	A.	29	42·0	13	43·3	42	42·4	
	B.	28	40·6	10	33·4	38	38·4	
	C.	12	17·4	7	23·3	19	19·2	
	Totals	69	100·0	30	100·0	99	100·0	
1953	A.	22	31·9	13	37·1	35	33·6	
	B.	34	49·3	16	45·7	50	48·1	
	C.	13	18·8	6	17·2	19	18·3	
	Totals	69	100·0	35	100·0	104	100·0	
1954	A.	13	21·0	10	20·8	23	20·9	
	B.	26	41·9	23	47·9	49	44·6	
	C.	23	37·1	15	31·3	38	34·5	
	Totals	62	100·0	48	100·0	110	100·0	
							52-54	49-51
Three years combined	A.	64	32·0	36	31·9	100	31·9	37·2
	B.	88	44·0	49	43·3	137	43·8	39·5
	C.	48	24·0	28	24·8	76	24·3	23·3
	Totals	200	100·0	113	100·0	313	100·0	100·0

Table 80. *Outcome of treatment.*

Three years shown separately. 313 inpatients (discharges).

*A. — recovered or much improved.
B. — improved or slightly improved.
C. — no change, worse or died.

20. Disposals: Inpatients

Table 81 shows the distribution which can be conveniently considered in four broad assortments (A to D). The disposals are multiple, 441 disposals having been made of 301 (out of 313) inpatients of whom disposals were made. (It is probable that the twelve undisposed-of children had been removed against advice. Discharges against advice were not coded).

Under a fifth (19·2 per cent) were referred back to a private doctor; under a third (31·6 per cent) received further treatment or supervision at the joint hospital; for 39 per cent residential treatment or accommodation outside was found; and of 51 per cent other disposals were made including the sending of reports to the following organisations and agencies (number of children in brackets): education authorities (105); probation service (12); social agencies (11); government departments (4). Thus a report to an education authority was sent on about a third of the discharged inpatients.

The coding during the two triennia has differed in small ways so that full comparisons are impossible. It will, however, be seen that in the second period relatively fewer patients were referred to the joint hospital's clinic for the epilepsies, to residential institutions other than hospitals, and to outside psychiatrists.

Disposals (multiple)	Boys		Girls		Total		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
A. To private doctor ...	30	15·0	30	26·5	60	19·2	11·6
B. Further treatment or supervision at joint hospital							
To O.P.D. for treatment or follow-up ...	56	28·0	31	27·4	87	27·8	—
To clinic for the epilepsies	5	2·5	7	6·2	12	3·8	8·5
Total	61	30·5	38	33·6	99	31·6	—
C. Residential treatment or accommodation outside							
To residential institution (non-hospital)	17	8·5	10	8·8	27	8·6	16·9
To non-psychiatric unit or hospital	3	1·5	2	1·8	5	1·6	3·5
To mental hospital as V.P.	5	2·5	5	4·4	10	3·2	1·8
To psychiatric unit outside	5	2·5	—	—	5	1·6	0·4
To foster home, residential school, etc.	55	27·5	20	17·7	75	24·0	—
Total	85	42·5	37	32·7	122	39·0	—
D. Other disposals							
To outside psychiatrist	11	5·5	10	8·8	21	6·7	10·2
To D.R.O.	—	—	1	0·9	1	0·3	—
Reports (see text) ...	85	42·5	47	41·6	132	42·2	—
Other disposal ...	3	1·5	3	2·7	6	1·9	—
Total	99	49·5	61	54·0	160	51·1	—
Total disposals ...	275	—	166	—	441	—	—
Total patients disposed as above	192	—	109	—	301	—	—
No special disposal ...	8	—	4	—	12	—	—
Total patients	200	—	113	—	313	—	—

Table 81. *Disposal by sex of children.*

313 inpatient discharges.

21. Disposals: Outpatients

Table 82 shows the often multiple disposals of 789 (out of 947) children of whom disposals were made. (The 158 children of whom no disposals were made had nearly all lapsed: Cf. table 83.) There were rather more non-disposed-of children in the second period (16·7 per cent) than in the first (13·5 per cent).

The disposals are partitioned in four assortments A-D. There were referred back to private doctors 28·7 per cent of children, a few less than had earlier been referred by private doctors (31 per cent: Cf. table 76); nearly seventeen per cent were admitted to hospitals, institutions or foster homes; just under four per cent were referred to outside psychiatrists; and, concerning 39 per cent, reports were sent to various departments, authorities, agencies and institutions. Such reports were sent to an education authority on nearly a quarter of all outpatients (24·5 per cent).

If the two triennia are compared the main difference will be seen to reside in the distribution of admissions to other places (assortment B). In the earlier period nearly all admissions were to the joint hospital (11·2 out of 11·8 per cent); in the second more than half (8·8 out of 16 per cent) were sent elsewhere—over five per cent to residential schools or foster homes.

Disposal (multiple)	Boys		Girls		Totals		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
A. To private doctor ...	164	25·9	108	34·4	272	28·7	31·1
B. Admission to hospital, institution or home recommended							
To joint hospital ...	55	8·7	21	6·7	76	8·0	11·2
To non-psychiatric hospital	—	—	1	0·3	1	0·1	0·2
To residential institution	16	2·5	4	1·3	20	2·1	0·2
To observation ward	2	0·3	—	—	2	0·2	0·2
To mental hospital as Voluntary Patient ...	3	0·5	2	0·6	5	0·5	—
To psychiatric unit outside	1	0·2	2	0·6	3	0·3	—
To joint hospital's neuro-surgical unit	1	0·2	—	—	1	0·1	—
To foster home, residential school, etc.	40	6·3	12	3·8	52	5·5	—
Total	118	18·7	42	13·3	160	16·8	11·8
C. Further treatment or disposal elsewhere recommended							
Referred to outside psychiatrist	25	3·9	12	3·8	37	3·9	5·9
Referred to Disablement Resettlement Officer...	—	—	—	—	—	—	0·4
To joint hospital's clinic for epilepsies ...	1	0·2	—	—	1	0·1	0·2
To joint hospital's adult department	—	—	—	—	—	—	0·1
Total	26	4·1	12	3·8	38	4·0	6·6
D. Reports and other disposals							
Report to probation officer or remand home	73	11·5	17	5·4	90	9·5	10·2
Report to Government department	2	0·3	1	0·3	3	0·3	1·4
Report to education authority	153	24·2	79	25·2	232	24·5	—
Report to other social agencies	25	3·9	16	5·1	41	4·3	30·2
Other disposal ...	10	1·6	5	1·6	15	1·6	5·0
Total	263	41·5	118	37·6	381	40·2	46·8
Total disposals ...	571	—	280	—	851	—	—
Total patients disposed of as above	526	—	263	—	789	—	—
No special disposal ...	107	—	51	—	158	16·7	13·5
Total patients ...	633	—	314	—	947	—	—

Table 82. *Disposals by sex of children.*
947 outpatients (discharges).

22. Mode of Leaving: Outpatients

The most noteworthy feature of table 83 is the improvement in the lapse-rate. In the first triennium nearly a quarter of the cases lapsed (a figure of 24·5 per cent compared unfavourably with one for 19·3 per cent for adults); in the second period, however, the lapse rate for children fell to below a fifth (19·5 per cent) which is lower than that for adults during the second period (20·8 per cent: Cf. table 30).

But as remarked in the first of these reports, lapses of attendance on the part of mothers do not necessarily connote failures of treatment. They may merely imply that the mother's standards of recovery or of normality are less exacting than the hospital's.

Mode of leaving	Boys		Girls		Totals		
	No.	%	No.	%	No.	Per cent	
						52-54	49-51
Discharged	508	80·3	250	79·6	758	80·1	75·3
Lapsed	121	19·1	64	20·4	185	19·5	24·5
Died	4	0·6	—	—	4	0·4	0·2
Totals	633	100·0	314	100·0	947	100·0	100·0

Table 83. *Mode of leaving by sex of children.*

947 outpatients (discharges).

23. Follow-up and Social Case Work

Of 947 outpatients 181 or 19 per cent were recorded as requiring to be followed up. This percentage is closely similar to the lapse-rate (19·5 per cent: c.f. table 83), as was the figure for the first triennium (follow-up rate 22·7 per cent, lapse rate 24·5 per cent).

Of 313 inpatients, social case work was undertaken for 250 or 79·9 per cent (first triennium 68 per cent); and, of 947 outpatients, for 385 or 40·7 per cent (first triennium 43·6 per cent).

24. Diagnosis

The International Classification (Cf. appendix) is unsatisfactory for the diagnostic grouping of children except in respect of clear cut categories which are the same for adults. Table 84 shows a simple six-point classification.

The 24 cases of mental backwardness and deficiency admitted to the wards were largely for diagnosis. The 101 mentally defective outpatients included a group whose parents sought a final opinion

before accepting the diagnosis. Psychiatric support to the parents of defective children is doubly important: it assists the patient and it stabilises what may be a disturbed family group.

The high proportion of inpatients who were psychotic (19·2 per cent) compared with outpatients (1·9 per cent) reflects an investigation in progress.

The fact that for inpatients the groups of behaviour disorders (28·4 per cent) and "other" disorders (28·1 per cent) add up to the large total of 56·5 per cent of all cases, and the fact that for outpatients these two groups make a still larger total of 73·4 per cent of all cases illustrate the inadequacy of these omnibus groupings. Behaviour disorders as shown may range from temper tantrums to arson, and "other" disorders from asthma to obsessional illness.

Hospital status and sex		Diagnostic group						Total
		Epilepsy	Mental def. and backw'dness	Behaviour disorders	Psychosis	Other organic diseases	Other	
Inpatients	Boys ...	15	14	64	38	18	51	200
	Girls ...	12	10	25	22	7	37	113
	Total ...	27	24	89	60	25	88	313
	Per cent	8·6	7·7	28·4	19·2	8·0	28·1	100·0
Out-patients	Boys ...	39	59	318	15	55	147	633
	Girls ...	23	42	140	3	16	90	314
	Total ...	62	101	458	18	71	237	947
	Per cent	6·5	10·7	48·4	1·9	7·5	25·0	100·0
Total (I.Ps and O.Ps) Both sexes	Boys ...	54	73	382	53	73	198	833
	Girls ...	35	52	165	25	23	127	427
	Total ...	89	125	547	78	96	325	1260
	Per cent	7·1	9·9	43·4	6·2	7·6	25·8	100·0

Table 84. *Diagnosis by sex and hospital status.*

1,260 in- and outpatient discharges.

CHAPTER SIX

DOMICILIARY CONSULTATIONS

by DENIS LEIGH, M.D., F.R.C.P.

1. Introduction

Since the inception of the National Health Service in 1948, general practitioners have been able to arrange specialist consultations in the patient's home. A family doctor may choose any consultant who has expressed his willingness to undertake this work, may contact him directly and with a minimum of bureaucratic formality avail himself of a Specialist Consultative Service. The only proviso is that the patient must be unable to attend hospital as an outpatient. The advantages of such a service in cases of psychiatric illness are at once apparent—the privacy, the presence of the family, the safeguard against hasty legal action provided for both patient and family doctor by an expert opinion have made psychiatric domiciliary consultations rank amongst the most popular innovations of the National Health Service.

The joint hospital was soon approached by family doctors with demands for these home visits. Starting in 1949 the domiciliary service has steadily expanded, so that over the years 1949-1954 the demand has increased fourfold. The domiciliary visit has three chief assets.

1. The patient is seen in his own social setting, in a friendly, informal atmosphere. His fears and prejudices against psychiatry and psychiatrists are allayed by this first contact in the home, and or 90 per cent of the patients, treatment or advice became possible on an entirely voluntary basis.

2. The visit does much to bring the family doctor more closely into the hospital orbit, and at the same time help him in a somewhat unfamiliar field.

3. The psychiatrist is brought sharply into a world of practicality. Practising a branch of medicine in which indecision is sometimes curative, and of less harm to the patient than decision, he is forced to decide certain issues there and then. His knowledge of general medicine is also tested, for 20 per cent of the patients proved to be suffering primarily from physical diseases.

2. Technique of Domiciliary Consultation

Experience has confirmed that a general practitioner prefers to contact the consultant with a request for a visit directly rather than through a domiciliary bureau. A clerical service dealing with requests for visits is essential, so that adequate records may be kept and there is as little delay as possible between the request and the visit. The degree of urgency may be difficult to assess; so if possible a visit is carried out on the day the request is received.

For preference, the patient is visited alone, the family doctor being consulted before or after the visit. Psychiatric patients often reveal to the psychiatrist information which they may withhold from the family doctor.

The ethics of the consultation, however, differ in no other way from those of other consultations. The family doctor is always regarded as the person in charge of the patient, and no patient is seen except at his request.

Full notes must be taken at the time, and a special printed sheet has been devised to fit in with the hospital records system.

3. Number of Domiciliary Consultations

Table 85 shows the number of visits carried out by the consultant staff of the joint hospitals in the years 1949-1954. Visits to women (numbering 1,017 or 72 per cent) much exceeded those to men (404 visits: 28 per cent). An analysis of the residences of the patients in terms of the London postal districts is also shown.

	London postal district	1949	1950	1951	1952	1953	1954	Total
Numbers	S.E.	47	62	87	106	144	159	605
	S.W.	28	55	103	137	153	181	657
	Total S.E. and S.W. ...	75	117	190	243	297	340	1,262
	W.	3	20	15	7	11	20	76
	W.C. ...	—	1	1	—	2	—	4
	E.	—	5	4	5	10	2	26
	E.C.	—	—	—	—	1	—	1
	N.	—	3	2	7	2	11	25
	N.W.	3	1	5	3	9	6	27
	Total outside S.E. and S.W.	6	30	27	22	35	39	159
	Total all London postal districts	81	147	217	265	332	379	1,421
Per Cent	S.E. and S.W.	93	80	88	92	89	90	88·8
	Other London postal districts	7	20	12	8	11	10	11·2
	Total	100	100	100	100	100	100	100·0

Table 85. *Domiciliary visits carried out by consulting staff of joint hospital from* 1949-1954 *in S.E., S.W. and other postal districts of London.*

1,421 visits.

It can be seen that the service is essentially a local one, 90 per cent of visits being made in the South East and South West postal districts surrounding the hospital. The figure is generally similar to

that of 83 per cent for total referrals by London doctors to the joint hospitals (Cf. table 101). An additional economic factor however is at work. It is uneconomic, in terms of time and money, for a consultant to travel from the hospital through the densely congested centre of London to the north or east of the city. Travelling time is an important factor in these visits. The result is that requests for consultations in outlying parts of London have been discouraged, the family doctor being advised to seek an opinion from a psychiatrist at his local hospital. It is also interesting to note, that although several consultants practise in the Harley Street area, visits in the West End have been very few (under 6 per cent of the total visits).

The total number of visits has grown from 81 in 1949 to 379 in 1954—a four-fold increase (table 85).

4. Number of Referring Doctors

Table 86 shows the total number of doctors referring patients, the number of patients referred by each doctor, and the number of consultants carrying out domiciliary consultations.

Year	1949	1950	1951	1952	1953	1954
Total doctors referring ...	57	81	117	132	155	185
Number of doctors referring:						
1 patient	49	58	84	82	93	113
2–3 patients	6	18	26	42	52	63
5–10 patients	1	4	5	8	7	8
Over 10 patients	1	1	2	—	3	1
Number of consultants undertaking domiciliary consultations	8	8	8	9	7	10
Per cent of doctors referring one patient only	86	72	72	62	60	61

Table 86. *Domiciliary consultations* 1949-54.

Number of referring doctors, number of patients referred by them, and number of consultants undertaking consultations.

This table shows that the total number of referring doctors has increased three fold. The bulk of the work (some two-thirds) however comes from about half of the total number of referring doctors. It would be strange, if calls were not made on other hospitals, that in many busy practices of between 2,000-3,500 patients, only one psychiatric patient per year is deemed in need of a domiciliary visit. This pattern is the subject of comment in chapter nine, where it is noted that 39 per cent of the doctors referring psychiatric patients to the joint hospital sent only one patient annually, and that, in 1954, 75 per cent of South London patients were referred by 43 per cent of the South London doctors who referred patients to the hospital.

5. Diagnosis

It has proved impossible to analyse the diagnoses of all the domiciliary consultations, as the record system to date has not encompassed systematic punching of the "domiciliary front sheets". As an indication of the range of diagnostic groupings, one consultant's personal records have been examined. The results are shown in table 87.

Diagnosis	1951	1952	1953	1954	Totals	
					No.	%
Depressive reaction	67	65	64	69	265	35
Neurotic reaction	54	59	54	56	223	29
Organic reaction	24	43	42	28	137	18
Schizophrenic reaction ...	14	15	18	13	60	8
Senile reaction	12	21	13	12	58	7
Others	10	2	4	6	22	3
Total visits	181	205	195	184	765	100

Table 87. *Diagnoses in domiciliary psychiatric practice.*
765 patients seen by a single consultant.

Depressive illness, under which is grouped both manic depressive and neurotic depressive reactions, is the commonest reason for a domiciliary consultation. The assessment of a suicidal threat or attempt is a matter in which the family doctor welcomes help from a specialist, and there is some evidence that the suicide rate in practices which have developed a special relationship to the hospital has been lowered since the domiciliary service began.

The neurotic disorders again form a surprisingly high proportion of "acute" cases. This is mainly the result of the reluctance of many patients, through prejudice or fear, to visit a psychiatrist. The concepts of the lunatic asylum and of the psychiatrist as a certifying officer still prevent many patients from seeking advice.

Organic disorders comprise 18 per cent of the cases, and range from cerebral tumours to delirious reactions. Probably the commonest are those mental states resulting from cerebro-vascular accidents, and presenting with dysphasic or confusional manifestations. It is easy to be misled by a physical condition presenting as a mental disturbance, and this is particularly so with delirious reactions. It is surprising how few schizophrenics have been seen; no explanation can be offered for this on the figures available.

6. Disposal

Table 88 shows the disposals made on these visits.

Disposals	1949		1950		1951		1952		1953		1954		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Inpatient at joint hospital ...	50	61·7	79	53·7	84	38·7	114	43·0	128	38·6	129	34·0	584	41·1
Outpatient at joint hospital ...	12	14·8	32	21·8	105	48·4	74	27·9	97	29·2	96	25·3	416	29·3
To mental hospital as V.P. ...	11	13·6	10	6·8	2	0·9	8	3·0	10	3·0	14	3·7	55	3·9
To observation ward ...	8	9·9	1	0·7	12	5·5	18	6·8	29	8·7	37	9·8	105	7·4
Other	—	—	25	17·0	14	6·5	51	19·3	68	20·5	103	27·2	261	18·3
Total	81	100·0	147	100·0	217	100·0	265	100·0	332	100·0	379	100·0	1,421	100·0

Table 88. *Disposal of cases seen in domiciliary consultation over six years.*

1,421 patients.

More than two-thirds of the patients were treated either as out- or inpatients of the joint hospital. During the six years the percentage of cases disposed of by admission to the joint hospitals' wards declined, that of admissions to its outpatient department reached a peak in 1951, and that of "other" disposals did the same in 1954. Under the last heading are included referrals to general hospitals, but most of these "other" disposals consist of advice to the general practitioner or to the patient or his family. Thus an increasing number of consultations give concrete help as a result of one home visit.

It is noteworthy that 90 per cent of these patients are dealt with on a voluntary basis, only 10 per cent (in 1954) needing to be sent to an observation ward. In view of the acute nature of most of the conditions leading to a domiciliary visit, this is a remarkable achievement. The most important factor is that the physicians carrying out the visits all have access to beds in the joint hospital, the majority indeed having their own inpatient units. The prestige of the joint hospital is high and its reputation well known, so that there is a willingness, indeed sometimes a demand, for admission. The small number (under 4 per cent in four of the six years) of patients sent to their area mental hospitals as voluntary patients were those whose admission could be safely delayed for about a week, and for whom no bed was available at the joint hospital.

7. Professional Relationships

(*a*) *Family doctor*

The introduction of the domiciliary visit has in many cases brought about a closer liaison between the family doctor and the psychiatrist. Visits to the doctor's house or surgery and a knowledge of the social structure of his practice are of particular value in a speciality such as psychiatry. At first the psychiatrist is very much on trial, both by patient and doctor. Family doctors do not like to "lose patients", and are sometimes apprehensive lest calling in a psychiatrist may alienate the patient, and cause him to change doctors. In fact the reverse has been true. In one district where a co-operative doctor-psychiatrist arrangement was made, the psychiatrist is widely known and patients have no hesitation in seeking his advice. The fact that a specialist opinion is so readily available in time of need becomes well known, and many doctors now find it an advantage to seek a second opinion.

The development of a friendly relationship with the family doctor is essential, not only where domiciliary visits are concerned, but for psychiatry in general. For this purpose it is advisable that the consultant should be freely available on the telephone, should speak as well as write to the doctor, and should not criticise him. Many visits which the doctor considers urgent are found by the psychiatrist not to be so, and the converse also occurs. The doctor is asking for help, and in many cases, is in doubt about the severity or urgency

of a case. A prompt response by the consultant is always helpful but it may put a strain on him since his appointments are usually already fully booked. In practice it means that most visits are done in the evening between 6-8 p.m.

The keynote of a successful general practitioner-psychiatrist relationship, however, is efficient disposal. The psychiatric emergency can cause a disturbance in a general practice out of proportion to its severity, and it is here that the assumption of responsibility by the psychiatrist is most welcome.

As in all consultations, the educational factor is two-sided. The consultant learns much. But so can those practitioners who do not take the view that psychiatry is a "closed book" to them.

(*b*) *the Duly Authorised Officer* (*D.A.O.*)

The relationship with the D.A.O. is more difficult. These officers have a delicate task which most discharge with notable success; but the independence vested in the D.A.O. by law is such that he can disregard the opinion of a family doctor or psychiatrist. The ensuing frustrations, which are happily rare, can impose severe stresses both on practitioner and specialist. The observation ward is an essential part of any psychiatric emergency service, and the co-operation of the D.A.O. is vital for the small number of cases who have to be handled in this way.

Again it is a matter of the psychiatrist taking pains to understand the standpoints of practitioner, patient and D.A.O. In fact there is now a satisfactory but unofficial arrangement whereby in awkward or disputed cases the D.A.O. advises the family doctor to ask for a domiciliary visit, the system working to the mutual advantage of all concerned. The important point is that the responsibility for requesting the visit is left with the family doctor.

(*c*) *Other psychiatrists*

Occasionally requests are made by psychiatrists not on the staff of the joint hospital for visits to their patients, or they have advised the patient's family doctor to arrange a visit from one of the consultants on the staff for this purpose. In general these requests have not been met, as the object of the visit is not considered to be the admission of patients to the joint hospital. This may lead to difficulties.

Apart from this, it is remarkable how psychiatrists' areas seem not to overlap. Little contact occurs with other psychiatrists on these visits, except when admission to an area mental hospital is necessary. Again a friendly relationship with the mental hospital psychiatrist is invaluable, and this again will depend on personal contacts.

8. Future Development of a Domiciliary Service

The provision of facilities for consultations in the home under the National Health Service has been an important development. The figures presented here show this quite clearly. About its value as a diagnostic and disposal service there is little to add.

The present day emphasis on keeping the psychiatric patient in his own milieu, out of hospital, is shown in the increased outpatient and day hospital facilities. Nonetheless these services are still centred around the hospital, and depend on patients' attendance. They do not cater for a group of patients who for one or other reason will not attend hospital. For instance, approximately 25 per cent of patients sent as emergencies to an observation ward are discharged after a stay of not more than 17 days. What happens to them after this is not known. Another question arises, whether, for some of these patients, the distress and upheaval caused by their enforced removal to a disturbed psychiatric ward, the traumatic effect on the patient and his family, was unavoidable. Arising out of the domiciliary consultation, it is possible to foresee a domiciliary treatment, or observation service. Indeed in Oldham and Nottingham such a service has been developed under the aegis of the Medical Officer of Health.

The aim of such a service might well be the treatment of the patient in his own home, whether by a medical, psychiatric or more purely social therapy. Such a scheme might involve the use of health visitors instead of psychiatric social workers; the D.A.O. might come to have a very different function from that which he has at present. In a city such as London, however, more difficulties would be encountered than in a relatively limited community such as Oldham.

9. Conclusions

The domiciliary consultation in psychiatry has proved its worth for patient, family doctor and psychiatrist. The number of consultations will continue to grow, and will be associated with an increased demand for outpatient and day hospital facilities.

CHAPTER SEVEN

THE MAUDSLEY DAY HOSPITAL

by ARTHUR HARRIS, M.A., M.D., D.P.M.

1. Introduction: Origin, Organisation and Purpose of Day Hospital

The Maudsley Day Hospital was opened on May 5th 1953. It may be described briefly as a ward the characteristic of which is that it is only open during the daytime on weekdays, the patients spending their evenings, nights and Saturdays and Sundays in their homes. It is accommodated in the ground floor of a Victorian house within the curtilage of the Maudsley Hospital, in rooms that formerly constituted quarters for senior nursing staff. There is a large room where most of the patients spend their day and which is used for occupational therapy of various kinds, discussion groups, games, play-reading, gramophone concerts and the like. A smaller room is available for those patients who need quiet and are not able to meet the social demands which the larger room makes. A doctor's office, a nurses' duty room and small kitchen in the basement, a combined bathroom and water closet and a small room on the first floor with a bed in which a patient can be given treatment involving rest such as modified insulin, complete the premises.

A total of 20 patients can be treated at a time. This number was reached by the end of June 1953 and the Day Hospital has been full ever since. In fact by August 1953 a considerable waiting list developed and this has persisted. On account of the restricted toilet facilities and other accommodation only women have been admitted. The pressure on female beds is, however, more acute than on male (c.f. chapter one, section 3), and in concentrating on the one sex the Day Hospital is fulfilling a particularly urgent need. One of the chief criteria of suitability for admission, as stipulated in a circular to the medical staff, is that the patient's condition must be such as would necessitate admission to an ordinary hospital bed if the Day Hospital did not exist. This has been closely adhered to, all the patients being so incapacitated by their illness as to be unable to work or to lead their normal lives. Most were quite unfit to be left alone at home during the daytime and admission to the Day Hospital often relieved a situation in which a husband or child was obliged to stay away from work to look after the patient. Patients should

not live much more than half-an-hour's journey away from the hospital, as greater distances prove too much after a time. Otherwise any patient who can be cared for at home at night and travel backwards and forwards between her home and the hospital is suitable.

Patients arrive at 8.30 a.m. and leave at 5.30 p.m. being as a rule brought and fetched by relatives or friends. In a small number of suitable cases this requirement is waived and they are allowed to come to hospital by themselves. Where relatives' hours of work do not fit in with these times they are allowed to bring the patient earlier or collect her later as the case may be, she being cared for meanwhile in one of the inpatient ward dayrooms. Mid-morning coffee and biscuits, a mid-day meal and afternoon tea are provided. The Day Hospital is closed on Saturdays and Sundays.

The nursing staff comprises a sister and a student nurse and the medical needs are met by a full-time registrar or house physician with one session a week from a consultant. The consultant in charge of outpatient psychotherapy is available for consultation regarding difficult psychotherapeutic problems. Nearly all the resources of the hospital are open to the Day Hospital patients in the same way as to the patients in the ordinary wards. Occupational therapy is done under the immediate supervision of the nursing staff with visits from occupational therapists to give advice, as in the other wards. Patients for whom special occupational therapy is required attend the occupational therapy department. Patients can attend P.T. classes and play tennis and other games. The full diagnostic facilities of the hospital are also available, including clinical laboratory, X-ray department, psychological testing and electroencephalography. Patients for whom E.C.T. is prescribed are given this treatment in one of the upstairs wards along with the inpatients between 9 and 10 a.m. so that they have plenty of time to recover before going home. The services of the psychiatric social work department are similarly available. In practice the demands made by the day hospital have been relatively slight and have not necessitated any expansion in the ancillary departments so far, although they may do so in the future. An ex-day hospital patient follow-up clinic, similar to the ex-inpatient follow-up clinic, is held weekly by the registrar or house physician.

The role played by the nursing staff is at least as important as in the more conventional type of ward and the success of the day hospital has been in no small measure due to the enthusiasm and ability of the nurses we have had. As a result of the single shift

system of working the nurse feels in close contact with all aspects of the patients' hospital life, in consequence getting a position in which she can exert greater personal influence and have a greater sense of individual responsibility. The simple type of organisation and absence of bed linen and other stock relieves the ward sister of administrative duties and enables her to devote the greater part of her time to the patients direct.

If a hypnotic is prescribed it is given to the relative to give to the patient when she goes to bed. The position can be summed up by saying that treatment differs little from that which the patients receive in the ordinary wards, the only treatments not available in the day hospital being insulin coma and leucotomy.

The advantages of the day hospital are economic, therapeutic and social. With regard to expense, the cost of running the day hospital is roughly one-third of that of running a conventional ward with equal accommodation for patients. There is only one nursing shift instead of three, there is no bed-linen or dormitory space, and kitchen and other domestic staff are needed for only a very limited time. Furthermore, the ease with which old buildings have been adapted to day hospital use has rendered new construction unnecessary and enabled a great saving in capital cost to be made. Conventional inpatient treatment removes the patient from the environment to which she will one day have to return and cuts her off more or less completely from her family and other associates. The artificial, sheltered atmosphere of the hospital is apt to produce a spurious improvement, so that apparent recoveries have to be tested by a laborious process of allowing the patient home for short periods, half-days, days, weekends and longer, before one can be sure that the patient is readapted to her normal life. The mere prospect of going out to face the world again often exacerbates her anxiety and produces a relapse. While the patient is in hospital her niche in the outside world may close. This is particularly liable to happen in the case of elderly persons living with relatives, although it is a danger with inadequate, dependent people of all ages. On the basis of the patient's absence, the family may rearrange itself, the possibility of disclaiming responsibility for her may come into their minds and she may find herself homeless and among strangers. Separation from children, husband or other loved ones may add to the patient's distress and increase her sense of guilt and despair. When we consider these disadvantages of admission to hospital the benefits of treatment on day hospital lines become apparent.

2. Statistics of First Twenty Months

The following tables and map (figure 1) relate to the patients discharged from the Maudsley Day Hospital in the period May 5th 1953 to December 31st 1954. There were 139 such discharges and, as the day hospital was full on December 31st 1954, 159 admissions.

It will be seen from figure 1 that the 139 discharges (shown by black-circled figures on the map) came from homes in the following areas:

London Postal District S.W.	...	49
S.E.	...	74
Outside S.W. and S.E. ...	...	6
Counties (Kent 9, Middlesex 1)	...	10
		139

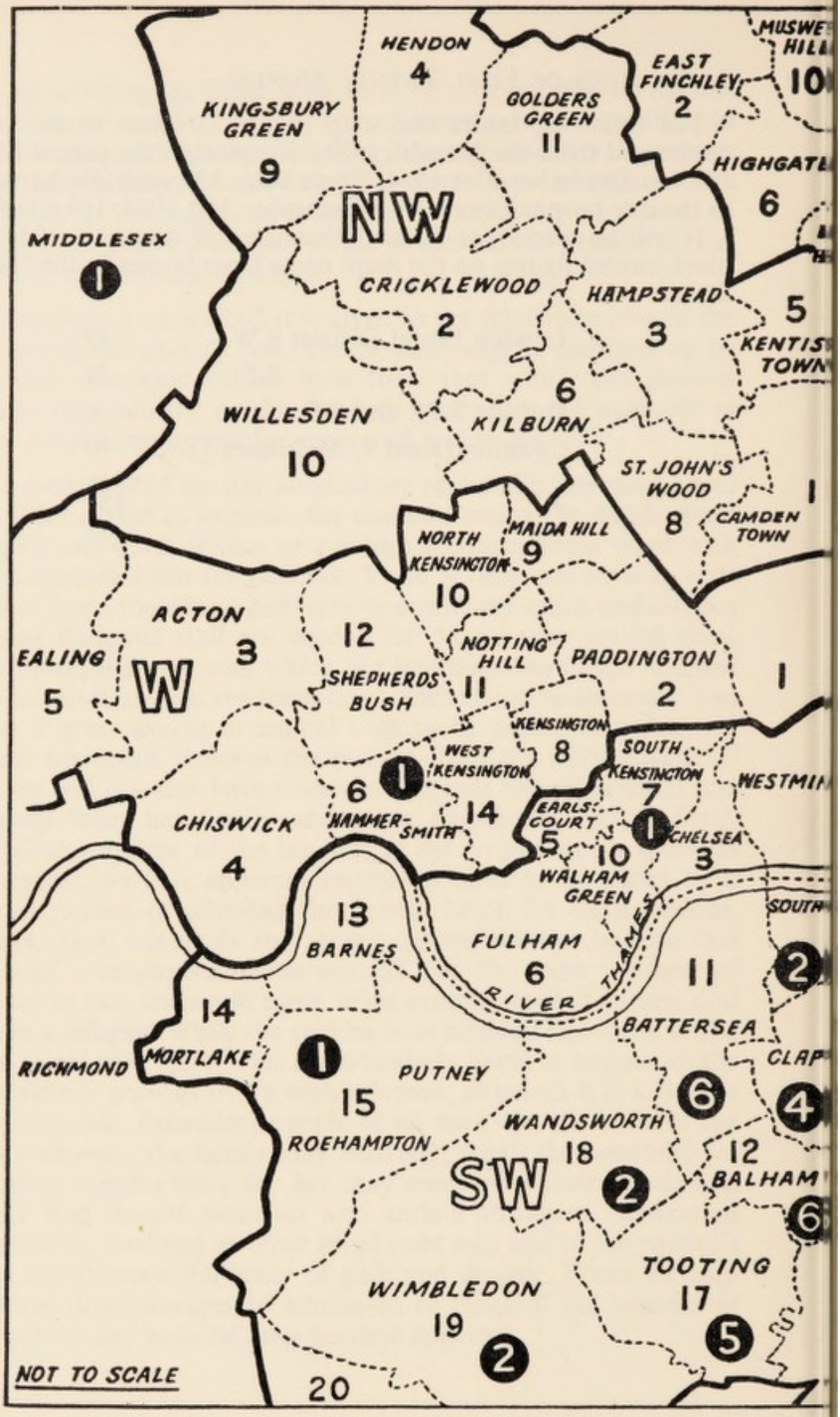
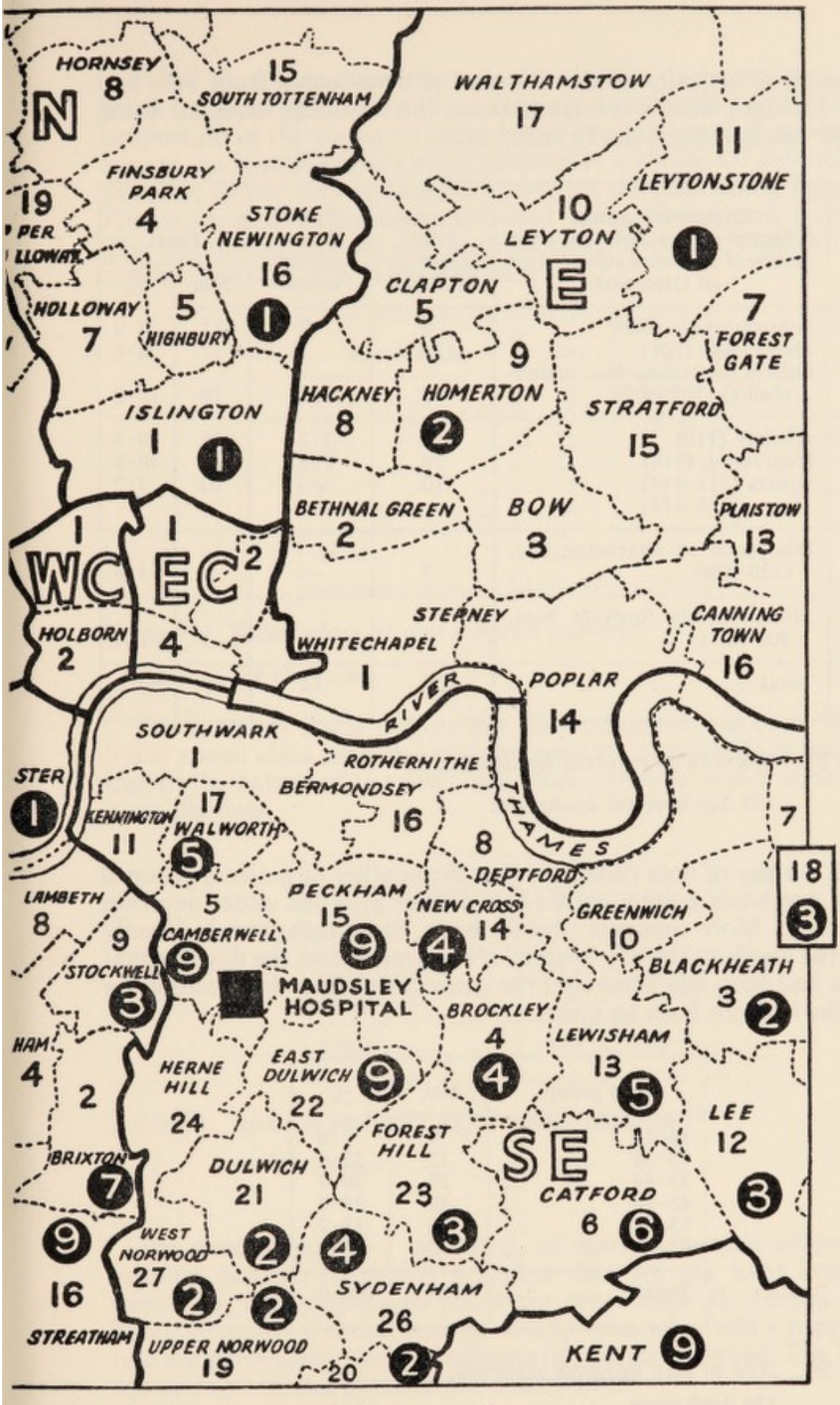


Figure 1. *Locations of homes of day hospita*
139 discharges from 5th May, 1953, to 31st December, 1954
other figures denote



patients by London postal districts and counties.

Figures in black circles denote numbers of day hospital patients; postal districts.

The great majority of day hospital patients come from S.E. and S.W. London, with a few from Kent, the Maudsley hospital being readily reached from the Bromley area.

	Diagnostic group (Figures in brackets are code numbers of International List of Diseases)	From joint hospital's O.P.D.	From joint hospital's wards	Total	
				No.	%
Psychoses	Schizophrenia (300) ...	9	2	11	7·9
	Depression (301)	34	3	37	26·6
	Others (including inv. melancholia) (302–309)	16	2	18	13·0
Psychoneuroses	Anxiety (310)	11	2	13	9·4
	Depression (314)	38	5	43	30·9
	Others (311–313) (315–318)	10	—	10	7·2
	Disorders of character, etc. (320–326)	5	—	5	3·6
	Miscellaneous (outside Nos. 300–326)	2	—	2	1·4
	Total	125	14	139	100·0

Table 89. *Sources of referral by diagnosis.*

139 day hospital discharges.

It is worthy of note (table 89) that the number of patients grouped under psychoses exactly equals the number grouped under neuroses (sixty-six). More patients would have been transferred directly from the wards to the day hospital if the pressure on the day hospital places had been less acute and the consequent delay in effecting the transfer had not been so great.

Age group	No.	%
16–24	8	5·8
25–34	32	23·0
35–44	29	20·9
45–54	39	28·0
55–64	26	18·7
65–	5	3·6
Total	139	100·0

Table 90. *Age of day hospital patients.*

139 discharges.

Table 90, which shows the age distribution, indicates that there was a higher proportion of the middle-aged and elderly and a smaller proportion of the young and very old in the day hospital group than among the joint hospital's adult patients as a whole. Of day hospital patients, 68 per cent were aged 35-64; the corresponding figure for female in- and outpatients combined being 50 per cent (table 3). The age distribution of day hospital patients corresponds with the age incidence of depressive illnesses.

Social class	No.	%
I	3	2·2
II	13	9·3
III	72	51·8
IV	24	17·3
V	15	10·8
Not known ...	12	8·6
Total	139	100·0

Table 91. *Social class of day hospital patients.*

139 discharges.

The tendency (table 91) for day hospital patients to come from a lower social class than the hospital patients as a whole is probably due to the nature of the catchment area, much of which consists of poor districts.

Marital status	No.	%
Single	31	22·3
Married ...	90	64·7
Widowed ...	14	10·1
Others	4	2·9
Total	139	100·0

Table 92. *Marital status of day hospital patients.*

139 discharges.

The percentage (64·7 per cent), of married women among day hospital patients (table 92) is higher than for the joint hospital's female in- and outpatients (56·3 per cent: table 4). This is partly because happily married women with spouses who fulfil a supportive role are particularly suitable subjects for the day hospital. The higher age of day hospital patients also contributes.

	Diagnostic group (Figures in brackets are code numbers of diseases)	Previously inmates of			No previous admission as inpatient	Total
		B.–M. hospital	Other psych. hospitals or units	Both one and two		
		1	2	3		
Psychoses	Schizophrenia (300)	2	–	2	7	11
	Depression (301) ...	8	4	10	15	37
	Others (302–309) including (involutional melancholia) ...	4	1	3	10	18
Psychoneuroses	Anxiety (310) ...	4	1	1	7	13
	Depression (314) ...	5	4	6	28	43
	Others (311–313: 315–318) ...	2	1	1	6	10
Disorders of character (320–326)		–	1	–	4	5
Miscellaneous (outside Nos. 300–326)		–	1	–	1	2
Total		25	13	23	78	139

Table 93. *Previous admissions to joint hospital and/or to other psychiatric hospitals or units by diagnosis.*

139 discharges from day hospital.

Sixty-one of the 139 (44 per cent) patients (table 93) had had previous inpatient psychiatric treatment. This is largely explained by the high proportion of depressive illnesses treated and the well known recurrent character of these conditions, which are particularly suited to treatment on a day hospital basis.

Diagnostic group (Figures in brackets are code numbers of diseases)		Number of attendances					Total
		1–4	5–12	13–25	26–50	50+	
Psychoses	Schizophrenia (300) ...	—	2	4	4	1	11
	Depression (301) ...	4	8	5	15	5	37
	Others (302–309) (including inv. melancholia) ...	2	2	4	8	2	18
Psychoneuroses	Anxiety (310)	2	2	1	1	7	13
	Depression (314) ...	1	6	8	14	14	43
	Others (311–313; 315–318)	1	1	1	3	4	10
Disorders of character (320–326)		—	2	—	2	1	5
Miscellaneous (Outside Nos. 300–326)		—	—	1	1	—	2
Total		10	23	24	48	34	139

Table 94. *Number of attendances by diagnosis.*

139 discharges from day hospital.

Table 94 shows the number of attendances at the day hospital by diagnosis. The largest group, those with between 26 and 50 attendances, correspond to a 5 to 10 weeks' stay in hospital. There is a tendency for neurotics to stay longer than psychotics, as one would expect.

Diagnostic group	Recovered or much improved		Improved or slightly improved		No change or worse	
	No.	%	No.	%	No.	%
Schizophrenic disorders ...	2	18·2	6	54·5	3	27·3
Manic-depressive reaction ...	21	56·8	6	16·2	10	27·0
Senile psychoses and psychoses with cerebral arteriosclerosis	—	—	1	100·0	—	—
Other psychoses (including involutional melancholia) ...	12	70·6	5	29·4	—	—
Total psychoses	35	53·0	18	27·3	13	19·7
Anxiety	3	23·0	5	38·5	5	38·5
Hysteria	—	—	2	100·0	—	—
Obsessive-compulsive reaction	—	—	1	25·0	3	75·0
Neurotic depressive reaction	19	44·2	21	48·8	3	7·0
Other psychoneuroses ...	1	25·0	2	50·0	1	25·0
Total neuroses	23	34·8	31	47·0	12	18·2
Pathological and immature personalities	2	50·0	1	25·0	1	25·0
Non-sexual delinquency ...	—	—	—	—	1	100·0
Miscellaneous	1	50·0	1	50·0	—	—
Total character disorders and miscellaneous	3	42·8	2	28·6	2	28·6
Total	61	43·9	51	36·7	27	19·4

Table 95. *Outcome of treatment by diagnosis.*

139 discharges from day hospital.

Table 95 shows outcome by diagnosis. It must be remembered that day hospital patients who get worse are often discharged from the day hospital and admitted as inpatients. The ultimate outcome for these patients may be excellent, but they load the day hospital figures in an unfavourable way. Some intractable neurotics were admitted to the day hospital in order to cope with social difficulties although no cure was hoped for.

Diagnostic group	To home	To home plus Maudsley O.P.D.	Admission to joint hospital	Other disposal	No disposal	Total
Schizophrenia (300)	1	8	2	—	—	11
Depression (301)	6	22	7	1	1	37
Others (302–309) (including inv. melancholia)	4	12	1	—	1	18
Anxiety (310) ...	2	8	1	1	1	13
Depression (314)	11	30	1	—	1	43
Others (311–313) (315–318)	1	6	2	—	1	10
Disorders of character (320–326) ...	3	2	—	—	—	5
Miscellaneous (Outside Nos. 300–326) ...	—	2	—	—	—	2
Total	28	90	14	2	5	139

Table 96. *Disposal by diagnosis.*

139 discharges from day hospital.

It will be seen (table 96) that 118 of the 139 patients were discharged to their own homes. The usual practice was to see such patients in a special day hospital follow-up clinic, although some were referred for more intensive outpatient treatment and some were for various reasons not seen subsequently in the outpatient department. None was admitted to other hospitals.

Order	Investigations	No.	Per cent
1	Wasserman or Kahn	71	51·1
2	Erythrocyte sedimentation tests	71	51·1
3	Blood count	23	16·5
4	Non-verbal intelligence tests	40	28·8
5	Verbal intelligence tests	39	28·1
6	Electro-encephalogram...	4	2·9
7	X-ray examinations	10	7·2
8	Cerebro-spinal fluid	2	1·4
9	Tests of deterioration	1	0·7
10	Bacteriological tests	2	1·4
11	Electro-cardiogram	2	1·4
12	Differential aptitude tests	1	0·7
13	(a) Other special biochemical tests	42	30·2
	(b) Other special psychological tests ...	3	2·2
	(c) Other microscopical tests	1	0·7
	(d) Other tests	4	2·9

Table 97. *Special investigations.*

139 discharges from day hospital.

Table 97 shows special investigations. The Wasserman and Kahn and the erythrocyte sedimentation tests were given as a routine to all patients on whom they had not been recently performed in the inpatient or outpatient department. All other investigations were carried out because of some definite indication.

	No.	Per cent
1. E.C.T.	63	45·3
2. Special drug treatment...	3	2·2
3. Modified insulin	3	2·2
4. Drug abreaction	1	0·7
5. Hypnosis	1	0·7
6. Group therapy	14	10·1
Total patient-treatments	85	61·2
Total patients treated	74	53·2
Patients who received no special treatment	65	46·8
Total patients	139	100·0

Table 98. *Special treatments.*

139 discharges from day hospital.

Multiple treatments included.

Special treatments are shown in table 98. The preponderance of E.C.T. is accounted for by the high proportion of depressive illnesses treated. Group therapy in this table refers to special groups run by the outpatient psychotherapists and consisting mainly of outpatients. The day hospital patients take part in group discussions led by the registrar with a limited therapeutic aim. These are not shown as receiving special treatment in this table.

3. Conclusion

This unit has been successful and felt by all to have made a worthwhile contribution to the therapeutic resources of the joint hospital in a particularly economical manner. Many patients who would otherwise have had to be referred to mental hospitals have been enabled by its presence to be dealt with by the joint hospital. It is proposed in the near future to expand and extend it, so as to be able to cater for more patients on a day basis.

CHAPTER EIGHT

GUY'S-MAUDSLEY NEUROSURGICAL UNIT

by MURRAY A. FALCONER, M.CH., F.R.C.S.

1. Introduction

The Guy's-Maudsley neurosurgical unit is a unique example of collaboration between two teaching hospitals, one a general hospital with a largely undergraduate medical school, and the other a specialist hospital designed for postgraduate students. The idea of a joint unit was conceived shortly after the War, and the unit came into being at the end of 1950 when it was housed temporarily in the York Clinic at Guy's Hospital. On October 1st, 1952, however, it moved to its permanent quarters in the Maudsley Hospital, where it occupies the ground floor of the former private patients' block. A new and self-contained operating theatre, E.E.G., and radiological block was provided for it by the Ministry of Health and by the two Boards of Governors out of their endowment monies. In November 1952 the new unit was declared open by the Rt. Hon. Viscount Waverley, G.B.E., F.R.S.

The day-to-day administration of the unit devolves upon the Maudsley Hospital, although the financial costs and policy decisions are shared between the two Boards of Governors. The unit when it opened at the Maudsley Hospital in 1952 had 14 beds in occupation, but thereafter it steadily increased its bed occupancy reaching its full quota of 28 beds by 1955. The unit is now staffed by two neurosurgeons and a part-time radiologist. Psychiatric, neuropathological, E.E.G., psychological and clinical laboratory services are provided by the Maudsley Hospital and the Institute of Psychiatry, while neurological, anaesthetic, and general medical services are supplied by Guy's Hospital. The nursing, radiographic and clerical staffs come under the Maudsley's administration.

2. Clinical Activities

Table 99 shows patients dealt with and operations performed in the neuro-surgical unit during the six years 1951-1956.

	1951	1952	1953	1954	1955	1956	Total	
							No.	%
Outpatients (at Guy's or Maudsley hospitals)	170	450	600	800	800	940	3,760	—
Inpatients								
Guy's Hospital ...	121	133	152	177	193	195	971	54·6
Bethlem Royal and Maudsley Hospitals	70	38	65	68	69	61	371	20·9
Other sources ...	25	37	59	87	109	118	435	24·5
Total inpatients ...	216	208	276	332	371	374	1,777	100·0
Major operations performed	138	143	181	243	229	212	1,146	—
Total operations performed	—	—	301	387	371	374	1,433	—

Table 99. *Patients under care of neurosurgical unit from* 1951-1956 *and operations performed.*

3,760 outpatients and 1,777 inpatients ; 1,433 operations.

It will be seen that, whereas inpatients referred from Guy's Hospital and from "other sources" have increased over the six years, those from the joint hospital have remained fairly constant: if the year 1952 be excepted, the figures have fluctuated between 60 and 70 per year. Over the six years, a little over a fifth (20·9 per cent) of patients dealt with in the unit were referred from the joint hospital.

The unit's patients have come from all parts of the British Isles. In addition the following patients have come from overseas—1951, 3; 1952, 3; 1953, 9; 1954, 15; 1955, 18; 1956, 12. The average period of bed occupancy in each year has ranged between 24 and 28 days.

All types of neurosurgical condition are admitted to the unit, and each year a detailed report has been published of the types of operation carried out according to diagnostic categories, with operative and case mortalities. A steady trickle of cases of brain tumour and even brain abscess have come through the joint hospital. Of perhaps greater interest, however, are the numbers of cases referred for leucotomy or epilepsy operations, for the majority of these are referred from the joint hospital (table 99*a*).

Type of Operation	Year						
	1951	1952	1953	1954	1955	1956	Total
Leucotomy (modified) ...	17	19	25	25	24	25	135
Temporal lobe epilepsy ...	3	6	17	19	13	14	72
Other types of focal epilepsy (non-tumorous)	—	3	3	3	2	5	16
Total	20	28	45	47	39	44	223

Table 99a. Leucotomies and operations for epilepsy.

In this series of 224 operations there were two deaths: one of a patient with temporal lobe epilepsy in 1951, the other of a patient undergoing leucotomy in 1954.

3. Radiological Work

The unit's radiological department acts also as the radiological department of the Maudsley Hospital. Table 99*b* shows attendances at the X-ray department: they are smaller than the number of X-ray examinations because the latter can be multiple for the same individual. The table shows that over half the work (55·7 per cent) is concerned with out- and inpatients of the joint hospital.

Whenever possible, specialised radiological techniques such as carotid arteriography and air encephalography are carried out from beds of the Maudsley hospital without transferring patients to the unit. Such patients do not count as admissions to the unit unless they are later transferred.

Patients from	Year				Total	
	1953	1954	1955	1956	Nos.	%
Neuro-surgical Unit (in-patients)	894	1,186	1,130	1,231	4,441	41.9
Joint Hospital (out- and in-patients)	1,298	1,433	1,604	1,569	5,904	55.7
Other hospitals	20	28	95	113	256	2.4
Total	2,212	2,647	2,829	2,913	10,601	100

Table 99b. Attendances at X-ray department during years 1953-56.

Note.—The figures do not include X-ray examinations done outside the unit and the joint hospital before a patient's admission to these places.

4. Teaching

Regular teaching ward rounds are conducted each Saturday morning, in conjunction with neurological colleagues from Guy's. Each week also a joint X-ray conference is held with the radiologist, and an E.E.G. conference is held with the Department of Clinical Neurophysiology of the Institute of Psychiatry. Generally also a special clinic is conducted each week for consideration of prospective patients for leucotomy and for follow up purposes. Fortnightly pathological conferences are held with the Department of Neuropathology of the Institute of Psychiatry. A sprinkling of registrars and postgraduates from the joint psychiatric hospitals attend all these conferences.

In addition since 1952 one or two Maudsley registrars have been regularly attached to the unit for periods of 6 months, gaining neurological experience both in the unit and at the Neurological Department of Guy's Hospital.

5. Research

The clinical research work of the unit has been conducted in four directions—leucotomy and modified operations, cerebral haemorrhage, hypophysectomy, and temporal lobe epilepsy. The latter field which was previously untilled has perhaps proved the most fertile and has been conducted jointly with the Departments of Clinical Neurophysiology and Neuropathology. Grants for a research assistant in this work have been given by the Medical Research Council since 1953, and more recently by the joint hospital's Board of Governors for a research psychologist.

The research into the comparative merits of various modified leucotomy operations is being conducted jointly with colleagues of the joint hospital. Likewise in the work on hypophysectomy for inoperable breast cancer, considerable help is being given by the Department of Psychiatry and the Department of Neuroendocrinology of the Institute.

A large number of papers in connection with these various researches have already been published, and work in all four fields continues to progress.

CHAPTER NINE

PRACTITIONERS REFERRING PATIENTS TO THE JOINT HOSPITAL

In the first of these reports it was shown that a minority of doctors could refer a majority of patients: of the practitioners in South London, 10·8 per cent had, in 1951, referred 72 per cent of the hospital's South London patients. The figures, it was said, "well illustrate how the volume of patients seen at a hospital is influenced by the referring habits of doctors."

How far do the figures for the second triennium confirm this finding? It will be seen from the following tables, which are drawn up on the same pattern as those of the first report, that, allowing for the somewhat larger number of referrals, events in the second period are little different from those of the first. The figures, it should clearly be understood, are of discharged patients *referred to the hospital by general practitioners*. In a total of 12,140 in- and out-patient discharges, 6,385 (52·6 per cent) had been referred by general practitioners, and it is upon these that the following comments and tables are based.

Table 100 compares the locations of practitioners and of patients referred by them. It will be seen that, in the course of the three years, between 76 and 79 per cent of practitioners, and between 85 and 87 per cent of patients lived in the London postal area.

It will also be seen that, in 1954, more doctors referred fewer patients than in 1953: in 1953, 850 doctors referred 2,280 patients (2·7 patients per doctor), whereas, in 1954, 879 doctors referred 2,060 patients (2·3 patients per doctor). The number of patients reached a peak in 1953, that of doctors in 1954.

The table also shows that, in 1954, more referring doctors lived outside London (24 per cent) than in the two earlier years (21 per cent). The figure of 24 per cent is thus similar to that for 1951 (Cf. first triennial report, table 81).

	Residence	Practitioners			Patients		
		1952	1953	1954	1952	1953	1954
Numbers	London postal area ...	653	675	669	1,766	1,984	1,746
	Counties	168	171	203	274	292	307
	Wales	1	1	4	2	1	4
	Scotland	—	2	2	—	2	2
	Abroad	1	1	1	1	1	1
	Total	823	850	879	2,043	2,280	2,060
Per Cent	London postal area ...	79	79	76	86	87	85
	Counties, Wales, Scotland and abroad	21	21	24	14	13	15
	Total	100	100	100	100	100	100

Table 100. *General practitioners referring patients to the joint hospital and the patients thus referred classified by location of practitioners (London, Counties and abroad). Numbers and percentages.*

Table 101 is concerned solely with the London area. As shown in figure 1 (page 125), the Maudsley hospital is situated near the boundary between the S.E. and S.W. postal districts of London (adult outpatients are not seen at Bethlem Royal Hospital), and drew most of its practitioner-referred patients (between 81 and 83 per cent) from these areas. The table compares figures for the S.E. and S.W. areas with those for other and more distant areas mostly north of the Thames. It will be seen that, throughout the triennium, the trend has been for more practitioners living outside the two southern or "local" areas to refer patients. There has, in fact, been a trend in this direction throughout the six years, the percentage of referring doctors living outside the two southern areas having risen from 26 per cent in 1949 to 32 per cent (table 101). Paradoxically, the figures for patients do not follow this trend, the reason being that doctors living near the Maudsley hospital commonly send up more patients than those living at a distance. The latter doubtless make use of psychiatric units in or near their postal areas and if they refer patients to the joint hospital it is often for some special reason, such, for example, as the hospital's inpatient facilities, which are unmatched in general hospitals.

	London postal district	Practitioners			Patients		
		1952	1953	1954	1952	1953	1954
Numbers	S.E.	282	284	271	895	1,029	939
	S.W.	189	188	184	539	584	515
	Total S.E. and S.W. ...	471	472	455	1,434	1,613	1,454
	W.	66	64	105	150	159	142
	W.C.	4	7	12	5	17	17
	E.	31	43	31	65	82	45
	E.C.	3	5	1	3	8	1
	N.	33	33	27	39	41	33
	N.W.	45	51	38	70	64	54
	Total outside S.E. and S.W.	182	203	214	332	371	292
Per Cent	Total (all London postal districts)	653	675	669	1,766	1,984	1,746
	S.E. and S.W.	72	70	68	81	81	83
	Other London postal districts	28	30	32	19	19	17
	Total	100	100	100	100	100	100

Table 101. *Referring doctors practising in London and patients referred by them classified by postal areas. Numbers and percentages.*

Table 102 shows the distribution of referring doctors and patients in thirty counties outside London (Scotland, Wales and the Isle of Wight being treated as counties). It will be seen that doctors in 25 counties were served in 1954 compared with 16 counties in 1952, the last figure being an unaccountable drop from that of 26 counties in 1951 (Cf. table 83 in the first of these reports). Of the thirty listed counties, Kent easily provides most patients; indeed it supplied 55 per cent of the County patients over the triennium. Surrey, Middlesex and Essex follow both in the numbers of referring doctors and of referred patients.

County	Doctors			Patients		
	1952	1953	1954	1952	1953	1954
Kent	65	62	83	158	162	169
Surrey	45	35	50	49	45	61
Middlesex	18	27	23	25	33	25
Sussex	5	4	6	5	4	7
Herts	3	8	5	3	11	5
Essex	15	14	9	17	16	9
Notts.	1	—	1	1	—	1
Yorkshire	—	1	—	—	1	—
Bedfordshire	—	3	—	—	3	—
Norfolk...	—	—	1	—	—	1
Suffolk	2	1	2	2	1	3
Oxford	—	1	1	—	1	1
Cambridge	1	—	2	1	—	2
Warwick	—	1	2	—	1	2
Bucks.	1	—	—	1	—	—
Dorset	—	—	1	—	—	1
Derby	—	1	1	—	1	1
Devon	2	4	1	2	4	1
Cornwall	—	1	1	—	1	1
Northants	—	—	1	—	—	1
Hants	4	3	5	4	3	6
Leicester	—	1	—	—	1	—
Berks.	3	—	1	3	—	1
Lancashire	—	3	2	—	3	2
Wiltshire	2	—	2	2	—	4
Gloucester	—	1	—	—	1	—
Cheshire	1	—	2	1	—	2
Isle of Wight	—	—	1	—	—	1
Wales	1	1	4	2	1	4
Scotland	—	2	2	—	2	2
	169	174	209	276	295	313
Number of Counties	16	20	25	16	20	25

Table 102. *General practitioners referring patients to the joint hospital and the patients thus referred distributed by counties* (*London postal area excluded*).

Table 103 answers the question how many "local" doctors (practising in S.E. and S.W. London) might have referred patients to the Maudsley, but did not do so. A list of doctors practising in the metropolitan boroughs, published at intervals by the London Executive Council, provides a rough base. The base is rough because the boundaries of the metropolitan boroughs and of the postal areas do not exactly coincide. Figures, moreover, were published by the Executive Council in 1949 and 1951 but not after. The figure for 1953 given below is the product of the assumption that the number of doctors increased between 1951 and 1953 as it did between 1949 and 1951.

It will be seen that, of 1,513 "local" doctors estimated to have been practising in South London during 1953 (the mid-year of the triennium), 472 (31 per cent) referred patients to the joint hospital. The majority (69 per cent) of South London doctors referred no patients to the hospital. The proportion of doctors using the hospital in the S.E. postal area (43 per cent) is larger than in the S.W. area (22 per cent).

Area of doctor's practice		Total number of doctors estimated to be practising in S.E. and S.W. areas of county of London 1953	S.E. and S.W. postal districts: number of doctors referring patients to joint hospital 1952	1953	1954	Percentage of doctors using joint hospital of all doctors in the areas 1953
S.E. London	a	665	282	284	271	43
S.W. London	b	848	189	188	184	22
Total ...	c	1,513	471	472	455	31

Table 103. *Doctors engaged in practice 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 in* 1953.

Table 104 shows how widely the referring habits of doctors vary. An average of 39 per cent of referring doctors residing in south London refer, each year, one patient only. At the other end of the scale a doctor practising in the S.E. area sent up in 1953 the largest annual number of patients for the triennium, namely twenty-seven—an average of about one a fortnight.

Number of patients referred by each doctor	S.E. postal district						S.W. postal district					
	1952		1953		1954		1952		1953		1954	
	Doctors	Patients	Doctors	Patients	Doctors	Patients	Doctors	Patients	Doctors	Patients	Doctors	Patients
1	102	102	103	103	85	85	88	88	86	86	80	80
2	57	114	44	88	56	112	36	72	26	52	40	80
3	41	123	34	102	34	102	19	57	20	60	20	60
4	16	64	29	116	27	108	16	64	13	52	12	48
5	18	90	13	65	23	115	5	25	12	60	6	30
6	15	90	16	96	5	30	6	36	8	48	7	42
7	11	77	13	91	16	112	5	35	6	42	7	49
8	6	48	9	72	4	32	3	24	3	24	2	16
9	1	9	5	45	3	27	3	27	2	18	4	36
10	6	60	2	20	8	80	1	10	4	40	1	10
11	4	44	4	44	1	11	1	11	2	22	3	33
12	1	12	3	36	2	24	2	24	3	36	—	—
13	1	13	2	26	3	39	1	13	—	—	1	13
14	—	—	2	28	2	28	—	—	1	14	—	—
15	—	—	1	15	1	15	1	15	2	30	—	—
16	2	32	1	16	—	—	—	—	—	—	—	—
17	1	17	—	—	—	—	—	—	—	—	—	—
18	—	—	—	—	—	—	1	18	—	—	1	18
19	—	—	1	19	1	19	—	—	—	—	—	—
20	—	—	1	20	—	—	1	20	—	—	—	—
27	—	—	1	27	—	—	—	—	—	—	—	—
Totals ...	282	895	284	1,029	271	939	189	539	188	584	184	515

Table 104. *Referring doctors and patients referred by them. S.E. and S.W. postal districts of London. Number of referrals by individual doctors.*

Table 105 brings out the main point which it is desired to make in this chapter, namely that the volume of patients seen at a psychiatric hospital is much influenced by the referring habits of doctors living within the hospital's catchment area. A minority of doctors can, through multiple referrals, send to a hospital a majority of its patients. Of the 1,513 doctors estimated to have been engaged in general practice in the south of the County of London area during 1953, the mid-year of the triennium, 14 per cent (213 of the 1,513) referred 80 per cent of the hospital's south London patients (1,284 among 1,613). It follows that if all the 1,513 doctors practising in south London had had similar referring habits to, and were otherwise *in pari materia* with, the 213 who referred three or more patients each to the joint hospital, the total number of patients seen during the year would have been magnified between five and six-fold.

	Doctors in general practice in S.E. and S.W. London in 1953	Patients referred by doctors in general practice in S.E. and S.W. London in 1953
(*a*) Total	1,513	1,613
(*b*) Total referring patients	472	1,613
(Total not referring patients)	(1,041)	(0)
(*c*) Total referring 3 or more patients ...	213	1,284
(*d*) Per cent (*c*) of (*b*) ...	45	80
(*e*) Per cent (*c*) of (*a*) ...	14	80

Table 105. *Numbers of doctors in general practice in S.E. and S.W. postal districts of London who referred three or more patients to the joint hospital in the year* 1953 *and the patients they referred.*

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 uraemia, 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

Schizophrenic residual state (Restzustand)

Schizophrenia, latent

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 praecox
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 type 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 paranoid 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
- anaesthesia
- 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 oesophagus (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 diarrhoea, 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
Miner's nystagmus
Occupational neurosis

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

320.6 *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

321.4 *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
- 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 intelligentiae

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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