It will be seen that the New Zealand Act of 1898 provides for the admission of all persons who could be admitted under the various English Acts, and that in addition it provides for the *compulsory* detention of habitual drunkards who may never have been "convicted" on account of drunkenness or any other offence.

The introduction of this power to *force* treatment in an institution on any inebriate for his drunken habits alone, quite apart from the question of his having actually stood in the dock, entirely changes the meaning of the term "voluntary patient." The majority of the patients admitted to the Orokonui Home on their own applications, and therefore claiming to be technically considered as "voluntary inmates," have really been forced in by their friends. Seeing that they could not escape from the law, they have made a virtue of necessity and applied for their own committal. They have entered the Home nominally of their own volition, but really under the shadow of compulsion. The following is as close an approximation as we can make towards a statistical classification of the headings under which the forty-eight patients who have entered the Home should be placed :—

True Voluntary Patients.		Nominally Voluntary Patients who have come in under the Shadow of Compulsion.		Non-voluntary Patients.		Total.	
Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
7	...	10	3	19	9	36	12

The first class corresponds fairly closely to the English "retreat" patients, but is not exactly identical, because absolutely destitute persons can be voluntarily committed in New Zealand, and this has been done in several cases. By this means a person against whom there had been repeated convictions in the Courts, and who would have been classed and treated as a reformatory case in England, gained admission to our institution as a patient on his own volition. In the second and third classes we have a certain proportion of patients corresponding to the English reformatory class, but even here the majority belong to a special class not provided for by the English Acts; and as regards prospect of recovery, these may be regarded on the whole as standing midway between the English "retreat" and "reformatory" patients. Few belong to what would be ordinarily understood as a criminal class, but they are mostly irredeemable drunkards who do not recognise, and cannot be *brought* to adequately recognise, the gravity of their condition or the misery it entails on their families, are not anxious to reform or to be reformed, and decidedly resent being compelled to forego their freedom for a time in order to give themselves a chance of restoration to physical and moral health.

It has been proposed repeatedly in England, especially during the last ten years, to make legislative provision for the compulsory detention of this class, but it has as often been pointed out how very hopeless any form of treatment must be without the sanction and help of the patient. Theoretically it has seemed arguable that, provided the person could be forcibly kept in healthy physical surroundings, and in a good moral atmosphere, and made to lead a regular, active life, apart from access to stimulants, it might be hoped to win him in a short time to see the error of his past ways, and thus to secure his hearty co-operation for the rest of the time during which he might need to remain under treatment. No doubt there are a few such cases, but they are very few. More or less complete restoration of bodily health may be confidently reckoned on. Usually there is improvement in the will-power and general mental faculties, and some return of moral sense; but, with few exceptions, a careful study of the case affords conclusive evidence of organic brain-changes, which place a limit on the progress which can be made in regard to both the mind and the moral outlook of the patient. There is no use in shutting our eyes to the fact that, when the delicate processes of the highest nerve-cells have been structurally destroyed and replaced by lower tissues, we cannot hope that we shall ever have the power of fully restoring the functions associated with the regions of the brain so involved. We might as well expect to obliterate an old scar on the surface of the body and restore its glands and functions without grafting on new tissue; and brain-tissue does not admit of replacement by grafting. Before the days when the microscope, aided by modern histological methods, was to reveal the intimate structure of the brain, and the ravages made by habitual drinking in the regions of the most specialised, the most recently evolved, and the highest ramifications and extensions of the nerve-tendrils peculiar to man, Dr. Moxon, the greatest of the earlier English pathologists, had said, "When the sot has descended, through his chosen course of imbecility, to the dead-house, morbid anatomy would tell you at the *post-mortem* that the once delicate filmy texture which, when he was young, had surrounded, like a pure atmosphere, every fibre and tube of his mechanism, making him lithe and supple, has now become rather a dense fog than a pure atmosphere—dense stuff which, instead of lubricating, has closed in upon and crushed out of existence more and more of the fibres and tubes, especially in the brain and liver . . . . and morbid anatomy would give evidence that such was the state of the drunkard long before he died. So that in vain you get him to sign the pledge. He signs too easily, because his brain is shrunken, and therefore he cannot reflect. And he breaks his pledge immediately, because his brain is shrunken and its membranes are thick, and therefore he has no continuity of purpose or will."

It needed but the most superficial knowledge of the pathology of the brain to enable one to say at once, of a certain proportion of the cases committed to Orokonui, that their brains were already in various stages of the irreparable structural degeneration described by Dr. Moxon. One patient