

Utrecht, Holland. In my recently published report upon mental deficiency and its treatment, I said "There is no universal 'best system' in this or the allied problem of dealing with the insane, and each country must evolve its own method, guided and restricted by its own peculiar racial, geographic, and economic situations."

In New Zealand we have tackled this problem in a manner which in many ways is unique, and I am satisfied that we are doing so on sound lines. The reception cottages and neuropathic units established at the main centres are meeting the demand for suitable accommodation for those early cases, and associated, as these already are at Porirua, with a treatment centre, the scheme is much more suited to the needs of our relatively small and scattered population than would be the erection of residential clinics of the types which I have mentioned.

#### OBSERVATION BLOCKS AT HOSPITALS.

Arrangements were concluded with the Police Department last year to ensure that no patient should be conveyed to hospitals in police vans, and that officers on escort duty should wear mufti; but there is still a serious flaw in our system—patients are still occasionally lodged in prison pending examination and committal. This can only be remedied by the erection at the main general hospitals of small observation blocks to accommodate between six and a dozen patients pending determination of their cases.

#### VOLUNTARY BOARDERS.

Many of the cases first seen at the clinics take advantage of the voluntary-boarder section of our Act, which allows them to enter a mental hospital of their own free will. The number of voluntary boarders admitted annually has increased steadily since 1911, when we adopted the principle, and last year no fewer than 197 persons, or 17·25 per cent. of our total admissions, secured early treatment in this way.

The advantages of voluntary admission are that the individual does not feel that he is detained against his will; he comes in furtherance of his desire for treatment, in which he, therefore, co-operates. He arrives at an early stage, is more likely to recover, and the duration of his stay in hospital is much shorter than that of the "certified patient." Apart from the benefit to the person concerned, these are matters of considerable economic importance to the community.

We are much in advance of Great Britain in regard to this matter. In England the voluntary-boarder system is applicable only to those who can afford to pay for treatment in private mental hospitals. In Scotland there is legal provision for the admission of voluntary boarders to the district (public) mental hospitals, but, as no Government subsidy is payable in respect of persons admitted in this way, the provision is largely non-operative, and the patient has little chance of treatment until he becomes certifiable and therefore less recoverable.

Admission as voluntary boarders is strictly limited, and rightly so, to those who can fully appreciate the nature of and the obligations imposed by the request which all applicants are required to sign, but it is important to realize that many persons who are too confused or unbalanced to sign a form would benefit by treatment at an earlier stage than that at which we now receive them.

#### CERTIFICATION.

Under present legislation the only alternative to voluntary admission is (except for minors) the issue of a reception-order after personal examination by a Magistrate and two doctors. This procedure, which is commonly known as certification, was originally devised in the days when custody, not treatment, was the keynote of asylum administration and was framed in order to protect the public from being kidnapped into madhouses. Now that treatment, particularly early treatment, is the objective, this cumbersome, and in any case ineffective, anachronism merely defeats its own object. Instead of protecting the public, it delays the institution of treatment at the stage when it is most likely to be effective.

The stigma which looms so largely in the public mind is very much related to certification. Patients on recovery, and their relatives in the early stages, feel humiliated at having to take the patient to Court to see the Magistrate, whose functions are largely related to wrong-doing and the punishment of offenders, and they put off taking the necessary steps until disorder becomes so pronounced as to demand drastic action.

The diagnosis of disease and the tendering of advice to the relatives as to appropriate treatment are duties which can be competently performed only by medical men of experience, and nothing is gained by the personal interview between the patient and the Magistrate. Without exception I have always found the Magistrates most kindly and considerate to the patients and their relatives at these interviews, but there are often embarrassing delays and prolonged waiting about Courthouses, which adds greatly to the distress of those most concerned. In remote country districts some difficulty is often experienced in getting the two Justices who may in certain circumstances act for a Magistrate.

In Scotland, where one never hears the word "stigma," these difficulties do not exist, because upon the application of the relatives, accompanied by two medical certificates, the patient may be received in the mental hospital and detained for three days. The documents are at once sent to the Sheriff (Magistrate), who sees that the legal formalities have been complied with and then issues a detention-order. I may add that there is no record in the Scottish law-courts during the last seventy years of any person having been improperly detained in a mental hospital.

In Scandinavia the procedure is essentially the same.

I would strongly urge that an amendment be made to our Act in the direction of adopting a procedure similar to that which works so admirably in Scotland.