MENTAL ILLNESS

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OUR conception of mental illness has undergone a great change during the last half-century and many old misconceptions have been discarded. Lunacy, a purely legal term, which corresponds to no medical diagnosis, has slipped into the background and mental illness is recognised as a wide range of conditions of varying seriousness about which there is a growing body of knowledge and for which, to an increasing extent, appropriate treatment can be given.

The effect of this change is striking. Early in the century the only recognised provision for mental illness was to be found in hospitals known as lunatic asylums, which were administered under the 1890 Lunacy Act. These hospitals were designed for and restricted to persons who, owing to their mental condition, were incapabe of managing their own affairs and who, for their own safety or that of others, needed to be placed under care and treatment. Treatment was legally provided for, but in practice the emphasis was on care and protection, and since admission to hospital meant the deprivation of the patient's liberty it followed naturally that elaborate provision was made for the prevention of abuse. It followed equally naturally that relatives and friends were reluctant to invoke the Act. The result was that the only hospitals able to provide resident treatment were closed to many who would gladly have taken advantage of it, and the Lunacy Act became only too often a barrier to treatment.

A way round had to be found and with the 1930 Mental Treatment Act legal barriers were swept away. The patient 'certified' under the Lunacy Act is still admitted under, and with the safeguards of, that Act but it is now fully recognised that a legal condition is no criterion either of the seriousness of the illness or of the need for treatment. The mental hospital can now accept patients who receive treatment at their own request and who are officially termed

https://doi.org/10.1111/j.1741-2005.1952.tb05182.x Published online by Cambridge University Press

voluntary patients. These are a growing proportion of our mental hospital patients, and together with the small group of temporary patients (patients who, although for the time being unable to make a decision for themselves, are expected to make relatively quick recovery) are helping to change the attitude of the community towards mental illness and its treatment.

The 1930 Act is an important landmark. It has given a great impetus not only to in-patient treatment but also to the early treatment of conditions, whether severe or slight, which could be treated in out-patient clinics; and to the after-care of patients who leave hospital. Administratively speaking, the new Health Act has carried this one step further and we now have a network of out-patient clinics covering the country within the framework of the Hospital Management Boards, while after-care which involves domiciliary visiting has become the responsibility of the Local Authority.

It would be rash to assume that all has now been provided for and that the rest can be left to the expert. This would be premature. To some extent the difficulty is one of time; new services will no doubt grow to the demands that are made on them and pruning will be effected where it is found that wasteful provision has been made. Our hospitals present a greater problem than this, however. Buildings are old and often ill-adapted to modern conceptions of treatment. The number of beds is insufficient for the wider service now demanded and the shortage of nurses keeps some of the existing beds empty. In all directions there is a shortage of trained staff, a condition which, in view of the man-power situation, we must probably look upon as more or less permanent. Even with the very considerable contribution that Irish nurses make to our hospital problem we need to husband our resources and to ensure that our hospitals are used to the best advantage.

The extent of the problem can be gauged to some extent from the figures of the Ministry of Health for 1950.[1] At the end of that year the number of patients in mental

1 Annual Report of the Board of Control for the year 1950. (H.M.S.O.)

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hospitals in England and Wales was 147,288. Of these 24,657 (16.7%) were voluntary patients, 395 (.3%) were temporary patients and 122,236 (83%) were under certificate. Mental hospitals are under legal obligation to receive patients sent to them under 'certificate' and these must therefore come first. In spite of overcrowding, voluntary patients have to be refused.

The Board of Control has drawn attention to one direction in which mental hospital provision is wastefully employed. While there has been an increase in all age groups (and as already indicated admissions are only limited by the number of beds available), there has been a proportionately larger increase in the number of patients over 65, until at the end of 1950 the percentage of patients over 65 was 19.1 of the men and 27.6 of the women. It is pointed out that many aged people do not require the elaborate treatment facilities of a large hospital and that the mentally infirm do not require to be placed under certificate as persons of unsound mind. Were alternative provision available, the temptation to fall back on the Lunacy Act as a method of securing care for this type of patient would be largely removed.

No social service can hope to achieve and maintain full efficiency without the informed co-operation of the community which it serves, and the services for mental health have the same claim on our interest as the better-known services for physical health. There are in addition special reasons why religious bodies should concern themselves with these services. Mental illness of its nature has a disturbing effect on the personality, the illness tends to be long and the hospitals at which treatment is given are often difficult of access. Relations and friends may find it a burden (sometimes an ungrateful burden) to keep in close contact, and not infrequently patients outlive their friends. For these many reasons the mentally sick have a special claim on us.

The problem is not to be solved by providing Catholic hospitals. We are fortunate in having one Religious Order (of Augustinian Nuns) which in its two homes provides for 150 patients; but there is no official support and a charge has to be made which restricts the range of usefulness. We have no similar provision for men. While many would welcome

https://doi.org/10.1111/j.1741-2005.1952.tb05182.x Published online by Cambridge University Press

and support efforts to provide for the treatment for priests and members of religious communities, more than this would not be possible. Basing our estimates on the proportion of Catholics to the population, we must assume that the number in the mental hospitals of England and Wales is in the neighbourhood of 10,000 and it is clear that we must look to other methods of helping.

All can interest themselves in the mental hospitals of their neighburhood; some can fit themselves for serving on Hospital Management Committees should occasion arise. Many more can give of their spare time to befriending patients. Mental hospitals are usually in rural parishes and the chaplaincy falls on the parish priest who must often feel very isolated in his uphill work. His own parish resources are inevitably limited and he should be able to look further afield for help. If the need were made known, many, one feels sure, would be prepared to work under guidance, visiting individual patients at regular intervals, providing them with papers and, in suitable cases, taking them out occasionally for the afternoon or day. This would go far towards breaking down the feeling that they are forgotten by the outside world: a feeling which, even if self-induced, can be the cause of much unhappiness and which militates against the success of treatment.[2]

Voluntary work of this nature is not easy. Rebuffs and discouragement must be expected and considerable demands will be made on the tact and commonsense of the visitor. There are, however, many with these qualities who would respond if the need were made known.

Another way in which chaplains and this section of their parishioners could, perhaps, be helped (but which is outside the power of the laity) might well be explored. The isolation referred to could be met if one or more of the Religious Orders could in each diocese take this as their

2 The serious effect of social isolation in our present civilisation has led Dr P. Halmos to make a study of the views of others on this subject, adding to it his own investigations, more particularly in a student group, in *Solitude and Privacy* (Routledge and Kegan Paul, 21s.). Most people are conscious of the harm that may result from isolation and a study of this nature is welcome.

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'mission' field, visiting and spending two or three days every three months or so at the hospital. Proximity must usually decide who is to act as week-by-week chaplain, but visits from a 'missioner' with special experience of this work could benefit the patients, while chaplains would welcome the opportunity that this gave them of discussing problems. Such a scheme (which perhaps already operates in some parts) would no doubt depend on the diocesan organisation; it would provide a possible background for the recruitment of lay volunteers and would also help to achieve the aim of bringing the mental hospital and the mental hospital patients into the normal stream of Catholic life.

At the stage of leaving hospital there is yet another way in which the Church could help without heavy cost. The step from hospital to normal surroundings and responsibilities can be a difficult one, particularly if the illness has been long and outside contacts few. It is not unusual for the doctor to recommend 'convalescence' before return home, and the Mental After-Care Association sponsors (or in some cases owns) a number of small nursing homes which approximate in type to a boarding-house with a nurse in control. The stay varies, but is generally not less than three weeks and allows a welcome period of adjustment. Would it not be possible for Catholic after-care-homes to be opened, one in the north and one in the south, so that this period of adjustment can be spent in specifically Catholic surroundings when desired? If such homes could be brought within the framework of the M.A.C.A., so that applications for admission and payments are made through that organisation, much of the business anxiety would be removed. Such homes are normally self-supporting.

Some of the existing after-care-homes have Catholic matrons, but this is not the same as a home run for Catholics on Catholic lines. We are fortunate, however, in that so many Catholics go into the mental health services and in doing so help to create an atmosphere in which religion is seen as important: a necessary background to all outside effort.

Before leaving the subject of how help can be given to patients coming within the scope of the Mental Health

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Services, some reference should be made to the Catholic psycho-therapist. Many seeking out-patient treatment ask to see some one of their own religion. Much time can be lost obtaining the necessary information. The Catholic Psychological Society, when it closed down a few years back undertook to promote a register of all Catholics engaged in psychological work and this has no doubt been attempted. Some method of making the appropriate part of this register available for consultation would meet a real need.

TEMPLEWOOD: A NOTE ON ITS WORK

THERE are very few Catholic mental hospitals and in England not a single place of treatment on Catholic lines for the admission of cases of neurosis. Templewood Nursing Home was originally started to meet a need of the day: to provide a place where priests and religious, too ill to work but not so disturbed as to require mental hospital treatment, could recover and at the same time lead a life in keeping with their religious vocation. These cases would ordinarily be made worse by the secular atmosphere of a public mental hospital. Suitable lay-men were also admitted. In 1937 a chapel built in the grounds was opened by the late Bishop of Clifton and a resident chaplain appointed. In 1942 a house on similar lines was opened for women, primarily for religious sisters, thus forming two groups within the one community, both under the direction of the chaplain and staff. Certain duties such as work on the farm was undertaken by the men, and others, such as domestic employment, were more suitably left in the hands of the women.

Further developments were possible on the women's side as the number of permanent helpers increased. These were drawn chiefly from those who had come as patients, but also there were those attracted towards the work vocationally. Gradually a regular community life was established with daily Mass, the recitation of the Divine Office in the Chapel

https://doi.org/10.1111/j.1741-2005.1952.tb05182.x Published online by Cambridge University Press