though experience in the United States suggests that this is unnecessary in the great majority of cases.

Penicillin is the drug of choice in the treatment of *congenital syphilis* in all its stages. It is particularly effective in the first two years of life. Excessive dosage should be avoided. A good working plan is to base the dosage on body weight, giving 200,000 units per lb. (450,000 units per kg.) and to space administration over 8 to 10 days. Thus, for a child weighing 7 lb. (3.2 kg.) total dosage would be 1,400,000 units. This may be given in individual doses of 20,000 units of crystalline penicillin intramuscularly every three hours, missing one dose at night. Thus the amount given daily would be 140,000 units and treatment would continue for 10 days. Alternatively, 150,000 units of procaine penicillin may be given in single doses daily for 10 days. For older children dosage is similarly based on body weight and the method of administration is the same. In these cases a preparation of procaine penicillin is to be preferred to crystalline penicillin, because it requires fewer injections.

Good results have been obtained in prevention of damage to sight by *interstitial keratitis* by local applications of steroid hormones. A good routine is to instil drops of a suspension of cortisone acetate (5 mg. per ml.) into the conjunctival sac at intervals of one to four hours, depending upon the severity of the condition. Suspension of hydrocortisone (5 mg. per ml.), and cortisone ointment (15 mg. per g.) have also been used with effect. The steroids suppress the inflammatory reaction and hold it in check until spontaneous cure occurs, so that the amount of residual damage may be reduced to a minimum. Prolonged treatment is necessary, because relapse follows if treatment is stopped too soon. The frequency of instillation is gradually reduced, after the acute stage, but drops should be continued once or twice a day for many months.

OUT-PATIENT ADULT PSYCHIATRIC CLINICS*

BY

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One of the greatest though not the most dramatic advances in psychiatry in the twentieth century has been the development of the concept of social psychiatry, the realization that cases of mental illness cannot be treated adequately in isolation from the community, and the growing awareness of the need for an integrated mental health service.

The first man to see this clearly was that very great psychiatrist Adolph Meyer, who in 1913 stated (Meyer, 1952):

"The great future of Psychiatry lies in the extension of the work beyond the hospital walls, but with the full experience that only hospitals can furnish. For this it will be necessary to look to the State hospitals not merely as Asylums but as centres of the Mental Health Work of the

Community. They must be manned by physicians trained to meet that task. To attract those who are in need of help they must establish out-patient departments to which teachers and physicians can send those who are not at their best but not in need of hospital care.

"We want to get out-patient departments and through them create a feeling in the community that our special hospitals are places for help, places from which to get the guidance of experience and directions as to prevention.

"In some communities it would be best to organize special mental organizations, using the available dispensaries as far as possible, doing emergency work and work in the form of after-care and placing of patients returned from hospitals, and serving as advisors in the decisions as to where to place patients or where to direct them.

"The ideal arrangement would be to have in connection with the dispensary at least one physician able to visit homes, assisted by Social Workers trained for investigation and for giving guidance to the patient and to the family and social unit.

"I want to urge upon you especially, that the numbers of physicians must be large enough for the hospitals to spare, once or twice a week, one or more members of the staff who will go out as dispensary physicians to community centres at distances from the hospital. My way of arranging that would be to have every ambitious hospital physician trained so that he can be sent out on certain afternoons to do extramural work in one of the centres of the district, where he will see the after-care and preventive cases together with local members of the profession who might take an interest in these conditions and work as local dispensary physicians."

Psychiatric Out-patient Clinics in Britain

Psychiatric out-patient clinics in Britain, however, were started independently of Meyer. So far as I am aware the only clinic of this kind in Britain prior to 1900 was at St. Thomas's Hospital, and, although there was a good deal of interest in the subject during the 1900s and several clinics were started, it was not until after the first world war that they became generally accepted.

Blacker (1946), writing of their history in England, states:

"The oldest and most active clinics were the spontaneous creations of voluntary hospitals where they were the product of the hospital's internal development. Attention had been drawn in the first world war to the successful treatment by psychological methods of what was then called shell shock. Neurotic illness in its various forms came to be recognized more clearly than formerly, and an optimistic view of the possibilities of treatment was prevalent. Cases of neurosis were usually referred to the neurological departments of hospitals, often by other hospital departments, but also by practitioners outside the hospital. Such patients sometimes caused embarrassment; there were few satisfactory facilities for treatment; adequate disposal was difficult, and these cases were apt to become chronic hangers-on, returning again and again for their bottle of medicine, varying little in their recital of symptoms and complaints, yet somehow sustained by a faith in the hospital. The predicament thus caused was frequently met by establishing a new Department of Psychiatry. With the establishment of such a department, facilities were created for dealing better with neurotic patients. Psychotherapy was arranged, a psychiatric social worker was often added to the staff, who furnished reports on the domestic and occupational background, and the psychologist often helped with intelligence tests. Under the Mental Treatment Act of 1930, local authorities began to make arrangements for providing out-patient treatment for psychiatric cases in their areas. The clinics thus

* Read to the Scottish Association of Mental Health in Glasgow on October 31, 1958.

established were almost always staffed by psychiatrists based on one of the mental hospitals, and were usually located in the local voluntary hospital."

Scotland, and particularly Glasgow, was, I am glad to say, early in the field, and I am indebted to Sir David Henderson for the following note of their development here: "It was in 1910 that Dr. Oswald, of Gartnavel, inaugurated an out-patient clinic at the Western Infirmary, Glasgow. During the 1914-18 war the clinic was closed, but in 1919, with Dr. Oswald's permission and with the co-operation of Colonel Mackintosh, who was the superintendent of the Western Infirmary, I reopened the clinic and appointed Miss McTavish to the position of social worker. The clinic became popular. I used it as a teaching centre for medical students and social workers. David Kennedy-Fraser also was of enormous help to me in tests for intelligence and education." Whatever was being done elsewhere, I know that Sir David had the views of his teacher and friend, Professor Meyer, very much in mind when he started his work at the Western Infirmary.

By 1939 the importance of the psychiatric out-patient clinic was widely recognized, but even then these clinics were unevenly distributed over the country, and in many areas they did not exist. It is only since the last war that a reasonably complete national coverage of clinics has been achieved. They are usually held in the out-patient department of a nearby general hospital, and work in them is accepted as a normal part of the duties of psychiatrists working in mental hospitals. In addition many of the larger general hospitals have their own department of psychiatry.

It must, of course, be remembered that the success of the out-patient clinic to-day, and its acceptance by the rest of the medical profession and by the general public, is directly related to the advances in psychiatric therapy which have taken place in recent years. To give only one example, advances in anaesthetics have made electric convulsion therapy a remarkably simple and safe treatment quite suitable for out-patient use.

Work of the Out-patient Clinic

The work of the clinic falls naturally into three parts—diagnosis, therapy, and support and aftercare. Initially the clinics were used mainly for diagnostic purposes, and this remains an important aspect of their work. The problems referred to the out-patient clinic include every type of psychiatric illness, as well as cases of physical disease where the referring physician believes that psychological stress is an aetiological factor. Patients are frequently sent for advice on sex and marriage, and there is an ever-increasing number of medico-legal cases. Many of the problems referred have no easy solution; some, indeed, may be insoluble, but there is no doubt that the work is rewarding and important.

The therapeutic role of the psychiatric out-patient clinic is just as important as the diagnostic. I am of the opinion, and I think that most psychiatrists would agree with me, that the majority of cases of psychoneurosis and many if not most of the cases of depression need not be admitted to hospital if adequate out-patient facilities are available. The admission of a patient to hospital inevitably disrupts his work and domestic life. The hospital environment, however good it is, separates

the individual from the community, and this may produce new stresses and anxieties which interfere with his progress and produce difficulties in rehabilitation.

Psychotherapy is often more effective and simpler when carried out on an out-patient basis, but, even so, it is time-consuming work which demands adequate staff, and there remains an acute shortage of properly trained psychotherapists throughout the country. Glasgow is more fortunate than most cities in this respect, as in addition to the out-patient clinics attached to the general hospitals it possesses the Lansdowne Clinic. This clinic, which was founded in 1936 by the directors of the Glasgow Royal Mental Hospital, is a psychotherapeutic centre of great value and importance. It treats patients referred both from general practitioners and from all the psychiatric units in Glasgow, and has always specialized in evening treatment, so that patients are able to attend without any interruption of their work. It is also a valuable centre for training young psychiatrists in psychotherapy, and its founders, and particularly Dr. McNiven and Dr. Yellowlees, are to be commended on their foresight and initiative.

The third main function of the psychiatric out-patient clinic is support and aftercare. In every society there are a number of people who, though not ill enough to require hospital treatment, need help on a long-term basis. Some are the victims of severe environmental stress; some are chronically anxious or subject to recurrent depression; some are cases of schizophrenia who though not acutely ill are eccentric and isolated; some are old, lonely, and frightened. To help these patients is an important part of the psychiatrist's work, though it is work that can be adequately done only in association with social workers, other social agencies, and voluntary bodies such as the National Association for Mental Health. It is essentially team work in which the trained social worker often has the key role, and it is most unfortunate that the number of psychiatric social workers continues to be quite inadequate throughout the country.

Specialization

It has always been the custom for the psychiatrist working in an out-patient clinic to handle all forms of psychiatric illness, apart from those occurring in children. On the whole this is a satisfactory arrangement and too much subspecialization is to be deprecated, but there are two groups of patients who I feel are best investigated and treated by doctors with special experience. Alcoholism is a pressing problem which is not being adequately handled in this country. In the United States and in several European countries special clinics exist for the alcoholic. During a visit to Holland some years ago I had the opportunity of seeing such a clinic and was deeply impressed by the work it was doing. In my opinion there is room for this type of clinic in every large centre of population in the country.

An extramural duty which psychiatrists often have to undertake is the examination of individuals charged with various crimes in order to determine their fitness to plead, whether or not they suffer from diminished responsibility, and whether or not they would benefit from psychiatric treatment. These examinations have been requested by the courts in increasing numbers.

especially since the passing of the Criminal Justice (Scotland) Act, 1949, and no other activity of the psychiatrist is given such publicity or, it must be confessed, excites more critical comment from members of the public. Yet in this country few psychiatrists have had any formal training in this specialized and difficult subject, and many lack the experience which is necessary if they are to help the courts to reach a correct and just decision. In the Scandinavian countries forensic psychiatry is a highly developed specialty. In Sweden, which has a population of 7 million, there are 14 centres of forensic psychiatry where offenders can be remanded for examination, and where they can obtain treatment by specialists paid by the State (Rylander, 1955).

The formation in this country of special clinics for forensic psychiatry is long overdue. Such a clinic, preferably working in association with a special hospital for psychopaths, could not only undertake examination of cases referred by the courts, but could give psychiatric treatment, where appropriate, both to prisoners and to offenders placed on probation. It could also undertake much-needed teaching and research. I understand that, mainly through the initiative and persistence of Dr. Inch of the Scottish Home Department, such clinics may soon be started in both Edinburgh and Glasgow.

Day Hospitals

An interesting and important advance in psychiatric out-patient care which has taken place during the past few years is the introduction of day hospitals. They have apparently existed for some time in Russia (Harris, 1957), but the first day hospital in this country was started quite independently by Dr. Bierer in London in 1946 (Bierer, 1951). Since then several have been opened in other cities in England. The day hospital is a natural development of the conventional out-patient clinic, and, as the name implies, patients spend the whole day in hospital but return to their own homes at night. This has a number of advantages. The patients can have intensive psychotherapy both individually and in groups; they can take part in occupational and recreational therapies, and can be given various forms of physical treatment. At the same time they do not lose contact with their homes and families, and their progress can be easily assessed. Another important advantage of treatment at a day hospital is its relative cheapness. Harris (1957), describing the Maudsley day hospital in London, states that its running costs are approximately one-third of those of an in-patient unit of similar size. Experience has shown that most types of psychiatric illness can be treated successfully in day hospitals. The most suitable patients are those with psychoneurosis who are seriously incapacitated by their symptoms, and all but the most severe cases of depression (Craft, 1958). Some patients, notably those suffering from confusional states and acute schizophrenia, cannot of course be treated in such a unit, and a further limitation is the amount of travelling involved. The day hospital naturally functions best in densely populated areas.

Another aspect of the day hospital is its suitability for caring for chronic psychotic patients who are not seriously disturbed but who are unfit to lead

independent lives, and who otherwise would have to remain in hospital. There is a definite need for centres for partially incapacitated patients, especially those recently discharged from hospital, where they can come for support and rehabilitation, and where they can undertake work under sheltered conditions in much the same way as do the physically handicapped in Remploy factories.

Amsterdam Psychiatric Consultative Bureau

A natural development of the out-patient clinic is the provision of an integrated community care service for all types of psychiatric patient. Hitherto our public health physicians and psychiatrists have had little professional contact with each other, but there is now evidence that they are converging both in theory and in practice (Shepherd, 1958). Much interest has been taken by psychiatrists in this country in the Psychiatric Consultative Bureau in Amsterdam, which is run by the city authorities and which has psychiatrists and social workers on duty throughout the 24 hours. Querido (1955) has described the work of the bureau in the following terms:

"When the family doctor or the specialist asks admission for a patient who is mentally disturbed, or when the police or any other body has to deal with a person who seems to be a mental case, the call is referred to a central point, which informs the city psychiatrist on duty.

"According to the nature of the call he sees the patient either immediately or within 24 hours and on the spot where the trouble occurred. If clinical observation seems to be indicated the patient either enters a psychiatric ward or goes direct to a mental hospital (this latter never happens with a new case), or he may decide that no admission is necessary and the patient remains under supervision. When legal measures such as an emergency order or certification are unavoidable, they are initiated by the bureau of the city psychiatrist.

"The supervision is carried out by visits to the patient's home. Patients under supervision may have been discharged from an institution, they may have been in the psychiatric ward of the general hospital, or they may never have been in hospital at all. No distinction is made between mental illness and mental deficiency. The consultation bureau also gives advice to the public assistance office, the city housing bureau, and the labour exchange. The bureau provides home help, placement in home care, sheltered workshops with a capacity of about 300, assistance in finding work, in procuring clothing, tools, and the provision of financial support.

"No treatment in the medical sense is given by the bureau, but patients are referred to the family doctor, polyclinic, or out-patient department. The function of the bureau is to assess the problems and difficulties of each patient, to estimate the amount of social pressure he can stand, and to relieve him from such burdens as he is unable to bear. Therefore, the material aid he may receive is to be regarded as medicine, to be dispensed according to his need.

"The majority of the patients under supervision are therefore those sufferers who probably would make a good adjustment in the hospital but who would stick at that stage if no other measures were taken. Schizophrenics, epileptics, some forms of paranoia, various types of psychopathy and hysterical personality, senile conditions, a few cases of general paralysis are, next to the mentally deficient, the type of patient under supervision. The work is partly curative, inasmuch as it tries to overcome the results of the disease, and partly educative, in that an adjustment is sought between the deficiencies of the sufferer and the demands of his surroundings."

The Worthing Experiment

Somewhat similar developments are taking place in England, notably in Worthing, Nottingham, and Oldham. In what has become known as the "Worthing experiment," the regional hospital board, with financial help from the Nuffield Trust, is undertaking a two-year experiment by providing an intensive out-patient and domiciliary treatment service in Worthing. This entails close co-operation between the local mental hospital, its out-patient clinics, the day hospital, and the general practitioners in the district, and a large number of domiciliary visits are carried out. Already there has been a marked drop in the number of patients admitted to the mental hospital. Dr. Carse, the physician-superintendent of the hospital, who is in charge of the experiment, and his colleagues (Carse *et al.*, 1958) have stated:

"Our experience at Worthing has convinced us that for a large proportion of psychiatric patients, admission to hospital is unnecessary and out-patient treatment can be entirely effective. Indeed, there is much to suggest that our mental hospitals have been carrying an unfair burden by being compelled to treat all types of patients without discrimination. It should not be thought, however, that our experience has led us to the conclusion that the mental hospital is an anachronism and redundant: indeed, our respect for it has increased. Now, however, we see it in its true perspective as a hospital for selected patients, mostly with a good prognosis, but needing special treatment and conditions which cannot be provided by an out-patient service.

"Each of us has had some difficulty in reorienting ourselves to this new form of psychiatric practice. We had accepted the idea that it was good for a patient with a mental illness to be removed to the artificial environment of a mental hospital and placed under control before he received treatment. In an out-patient treatment service it is never possible to divorce the patient from his family and background, and indeed from his own doctor. We ourselves, therefore, have had to make some readjustments."

In a similar vein Macmillan (1958) has stated:

"The system of community treatment which I believe offers patients the best care at all stages of their illness is a comprehensive service which treats all mental illness, including the chronic psychoses. This means that the mental hospital must take an active part in the scheme and is the most practical way of using our existing resources. It also means that we must alter our attitude to the chronic patients, and establish a personal relationship with them.

"In a service of this kind admission to hospital is not restricted. It is still promptly available, but it is limited to short-term episodes in a course of treatment which is based on the home. Admission and discharge are arranged in a flexible way with a minimum of formality. The function of the hospital is altered and modified, so that it becomes only one part, but an essential part, of the service. The resources and energies which would otherwise be spent providing long-term residential accommodation for patients can be diverted to domiciliary and community activities. The emphasis in the scheme of therapy moves from the hospital to the home, with community treatment playing an important part in all psychiatric illnesses. The patient retains his social and economic independence, and the mental hospital, like the general hospital, offers him specialized in-patient treatment when the resources of the home and the domiciliary and community services become temporarily unable to cope with his illness."

These views may seem visionary, and indeed there is a risk that if they are adopted uncritically too great a

burden will be placed on relatives and on the community as a whole, and public opinion will be alienated. Nevertheless they are important because they formulate, however partially, what I believe to be the kind of psychiatric service that is going to develop throughout the country in the near future.

It is worth recalling that they were accepted in principle by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, which issued its report in 1957. Although this report confined itself to the law of England and Wales, it is certain to play an important part in influencing future mental health legislation in both England and Scotland. It states, for instance: "In relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospital as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past." It devotes detailed attention to the problem of the mental invalid who does not require to be in hospital or has recently been discharged from hospital, and suggests that local authorities should be responsible for all community care. This, it states, would include the provision of residential hostels for individuals who are not fit to lead independent lives. I am dubious of the necessity or practicability of such a step. While close co-operation between local authority and mental hospital is essential for the success of any mental health service, I feel that the community care of the mentally ill invalid should be the responsibility of the mental hospital or psychiatric clinic through its out-patient clinic and day hospital, and that patients too ill to live in their own homes in spite of these aids should be admitted or readmitted to hospital without formality or delay. Continuity of treatment and supervision is surely more important than administrative tidiness.

Conclusion

I should like to end with a quotation from a World Health Organization Report on Mental Health (W.H.O., 1957): "The adequately organized psychiatric hospital with its extensions into the social life of the community and firm links with other branches of public health is a rational starting-point and base camp for a truly efficient mental health service. There is no time to be lost. Mental illness in all its forms is responsible for an incalculable amount of human suffering and financial loss. It is true that any sort of reform in the care and prevention of mental illness will cost money. But there are now good reasons for believing that a surprisingly good return in terms of both human happiness and national economy may be expected from even a modest outlay."

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