# ANNOTATIONS

## MENTAL ILLNESS IN LONDON[1]

THIS publication represents a substantial contribution of mental hospital statistics, a useful commentary on some of the methodological problems, and a monument to a colleague who in her short period of interest in mental hospital data produced this useful study which will have to be kept on the same reference shelf as the studies by Malzberg, Dayton, Odegaard, Kramer, and their like.

London has psychiatric "observation units" which apparently serve functions similar to many American psychopathic units. The City is also served by a number of government mental hospitals whose functions are in many ways analogous to American state hospitals. Dr. Norris has made a statistical study based on all admissions to two of the observation units and three mental hospitals during 1947, 1948, and 1949.

| | *Beds* |
|---|---|
| Observation Unit A | 82 |
| Observation Unit B | 76 |
| | 158 |
| Three Mental Hospitals About | 7,000 |

| | *Admissions* | |
|---|---|---|
| | *Men* | *Women* |
| Observation Unit A | 1,502 | 1,851 |
| Observation Unit B | 2,878 | 2,770 |
| | 4,380 | 4,621 |

[1] Norris, Vera: MENTAL ILLNESS IN LONDON. Maudsley Monographs No. 6. London, Institute of Psychiatry, 1959, 320 pp. 35s.

| | | |
|---|---|---|
| Of These, Transferred to Mental Hospitals Surveyed | 2,831 | 3,482 |
| plus Direct (= "straight") Admissions to Mental Hospitals Surveyed | 588 | 797 |

Data are provided for each of these groups of patients. The data sheets on which information was recorded are reproduced at the end of the book and the coding instructions on the immediately preceding pages. The data were obtained from the hospital records. Part of the data have to do with "follow-up" until 31 December 1951 to determine which of the following categories described the patient's subsequent experience with these hospitals:

A. Died in observation unit.
B. Transferred to mental hospitals.
   i. Died there.
   ii. Remained there until 31 December, 1951.
   iii. Transferred to other mental or general hospital, or other special hospital.
   iv. Was discharged and was readmitted prior to 31 December, 1951.
   v. Was discharged and not readmitted prior to 31 December, 1951.
   vi. Discharged to non-medical institutions or own home.

Some attempt was made to get this information through visits to thirteen mental hospitals to which patients had been transferred. Information was also obtained from the Board of Control. While these steps undoubtedly increased the number of patients with completed information, it is very hard for the reader to judge from the description on pp. 17 and 18 which categories of patients were most affected by these steps. The function of possible bias in the results is considerable since when patients who were discharged home from mental hospitals were not found to have been readmitted, they were assumed to have survived without subsequent psychiatric contact. Hence all readmission rates reported are underestimates to an unknown extent.

The information recorded on the data sheet included the

usual identifying characteristics, records of prior mental hospital admissions, diagnosis, legal status, disposal, duration of stay, number of subsequent admissions (and their durations), state of patient at end of follow-up.

A medical statistician can obviously make a series of tables from such a body of data which would throw light on many questions important to those interested in the operation of mental hospitals, to those specially concerned with the field of psychiatric statistics and to persons concerned with understanding the nature and extent of mental health problems. These data might also be used to illustrate and illuminate some characteristics of a government medical service and certain features of institutional sociology. Dr. Norris was interested in the first group of questions, but paid little attention to the second. She has provided a rich body of information which is reported in sufficient detail for the reader to get a complete picture of how she arrived at her tables, if he is willing to follow her descriptions carefully. Because of the complex nature of her sample it is necessary at times to search for exact descriptions of her sources of data for a particular table. Tables and graphs are not adequately labeled for this purpose and it is necessary to read widely in the text to get a picture of their contents at times. The absence of an index or list of tables makes this time-consuming but it is generally worth the effort.

*First Admission Rates.* The three mental hospitals were assigned catchment areas in 1948 when the National Health Act went into effect. Dr. Norris assumes that, in effect, they served the same catchment areas during 1947 and computes age-specific first-admission rates based on this assumption. These are rates to "mental hospitals" and do not take account of admissions to "observation units." ("Observation units" do not have "catchment areas" in the same sense.) These age-specific admission rates are considerably lower than those to which American investigators are usually accustomed. Her first-admission rates are about 53 per 100,000 population per year. For comparison, in New York City in 1957, Staten Island had a first state mental hospital admission rate of 66 per 100,000 per year, and Manhattan Island one of 180. These contrasts may be due to a number of different factors and are empha-

sized here only to highlight the fact that "mental hospital statistics" represent very different kinds of experience with mental disorders and are not subject to easy glib interpretations.

Dr. Norris was well aware of this fact and went to considerable trouble to unravel some problems in the presentations of her data. One of the important factors affecting admission rates is the population's age distribution. Various devices have been developed to eliminate the effect of differences in age distribution in the population at risk. Dr. Norris' book has a long chapter on computations of "expectations" and "expectancies," a favorite means of psychiatrists for summarizing the mental hospital admissions of a population. This chapter is the best introduction to the concepts of "expectancy" and "expectation" which this reviewer has seen. However, it would appear wiser to pay more attention to age-specific rates when comparing two populations than is usually done. This book gives us a rich supply of new age-specific measures. There are, however, few comparisons of age-specific first-admission rates in different places. These differences are very great.

Indeed, while the contrasts are not as great as between London and New York, there were important differences in the three hospitals within London. Dr. Norris drew attention to these differences, pointed out that there are important differences in the characteristics of the populations being served, and then wisely hesitated to attribute these differences to the differences in economic and social characteristics of the populations in the different catchment areas. She pointed out (quite rightly) that these differences can also be produced by differences in the organization of and utilization of the psychiatric services available to the different populations. Indeed, it would appear that her data throw more light on the variability of psychiatric service practices than on any other single question. Such variations in the organization and use of psychiatric services are referred to in this book as "nosocomial factors," following Svendsen. It is this reviewer's impression that these are not most fruitfully regarded as distorting factors but as the subject of investigation. This is, however, a minority view, and Dr. Norris was following the usual mode of thought

when she described her statistics as data about mental illness (unfortunately influenced by "nosocomial factors") rather than as data about the mode of operation of the psychiatric services. Of course there is some argument for looking upon data referring to the flow of patients into and out of mental hospitals as the product of the cases existing in the population served and of the way in which the psychiatric service functions in relation to that population. However, it would appear that Dr. Norris' data adds to the accumulated experience which suggests that, in practice, a mental hospital can almost always find a much larger number of patients suitable for the care it gives, than it ever does in fact find. If this is true, then, in practice, the hospitals are always selecting patients from a very large potential pool. If that is the case, hospital admission rates and their variations tell us much more about this process of selection than they do about the pool. About all they can tell us about the pool is that it is very much larger than the numbers reported by the hospitals. It would seem to this reviewer that Dr. Norris' data could be examined from this point of view in the light of information about the other characteristics of the hospitals she studied (staffing patterns, ward organization, policies and directives of an administrative nature, and so forth). Such studies could teach us something about the way in which admission rates are affected by styles of organizing and operating mental hospitals. This is another way of saying that the "nosocomial factors" can be investigated rather than lamented.

Dr. Norris began to approach this type of problem when she made the most detailed analysis yet published of the relationship between diagnosis made at an observation unit and diagnosis made at the mental hospital. These data are printed in the appendix and deserve careful study. They are referred to in the text to indicate that psychiatric diagnosis is not just an arbitrary random assignment of labels to cases, and that there is an improbable amount of agreement as between the diagnoses in the different institutions, if that were the case. These tables could undoubtedly be used for more refined analysis of the specific types of disagreements or diagnostic changes which occurred as between units. Had Dr. Norris continued to live

she might well have provided us with a number of papers on this topic. Fortunately, there is enough detail published in these tables so that others can do with her data what she was unable to do.

*Follow-up.* Some new data are provided on the amount of time spent in mental hospitals following admission for various diagnoses. This is expressed not only in survivorship in the hospital populations but also in the accumulated total of hospital weeks during subsequent readmissions. These figures count time on books of the hospital (whether residing in the hospital, on leave, or on trial) as days of hospital care. This unfortunate tradition in American mental hospital statistics has made analysis of this type of data almost meaningless, but Dr. Norris say that such periods are a trivial matter in her data. On page 22 the following data appear (referring to certified patients only):

| | |
|---|---|
| On trial for 4 weeks | "some" |
| Eight weeks | 5 per cent |
| More than 6 months | 1 per cent |

These facts are of some help in interpreting the length of stay and total duration of hospitalization after admission, but since we are not told whether the long trial patients were bunched in any of the subcategories for which durations are analyzed, we remain more uncertain than necessary of the importance of the variations shown in different age and diagnostic groups. Even so, the data on pp. 134 and 135, justify her pessimistic attitude toward subsequent life outside of hospital for schizophrenics. It would appear that during the few years subsequent to a first admission with this diagnosis, the admission cohorts spent much more time in the hospitals than out. This observation must be taken in conjunction with the fact that half the admissions to these hospitals were discharged within less than nine months after admission. Unfortunately the interpretation of these data is not illuminated in the text by recognition of the concept that excessive hospitalization can be destructive and lead to more hospitalization. Judging from the data made available in the text, the hospitals studied were not examples of newer trends in British and American psychi-

atry towards keeping periods of hospitalization short and minimizing the disability of patients while in hospital. While it is not possible to come to very firm conclusions on the basis provided in this publication, Dr. Norris has added substantially to the devices for looking more closely at the details of hospital patient flow.

This rather lengthy review of a meaty publication does not give a clear picture of the monograph. It gives, at best, some notion of the type of data to be found in the book and some notion of the reviewer's hesitancy in accepting all of Dr. Norris' conclusions. It also suggests, it is hoped, by some examples, the potential usefulness of the data to those with special interests in this field.

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## HEREDITY COUNSELING[1]

THIS is a collection of papers presented at a symposium sponsored by the American Eugenics Society. The first part is a discussion of genetics in medical practice by representatives of four fields: pediatrics (J. Warkany), dentistry (C. J. Witkop, Jr.), public health nursing (Helen Dyson, Witkop, and Shirley Butters), and cardiovascular disease (V. A. McKusick). The second part is devoted to genetic counseling with contributions from L. R. Dice, J. V. Neel, C. N. Herndon, F. C. Fraser, F. J. Kallmann, S. C. Reed, C. P. Oliver, H. F. Falls, and W. J. Schull.

As is almost inevitable with its many authors, the book is diffuse, repetitious, and uneven. Many of the ideas will not be new to readers of this journal. But it does put on record the views of an appreciable fraction of the active genetic counselors on this continent, and can be read with profit by anyone interested in the problems of genetic counseling.

Dr. Warkany emphasizes the difficulties of distinguishing

[1] HEREDITY COUNSELING: Edited by Helen G. Hammons. New York: Paul B. Hoeber, Inc., 1959. Pp. xiv + 112. $4.00.