buted an admission, and every 1,529 a first admission. The previous decennial average was 7·42 and 6·07.

The total number of patients discharged (excluding transfers) was 415 (m., 202; f., 213), of which 331 (m., 160; f., 171) were discharged as recovered. The remaining 84 (m., 42; f., 42), though not recovered, were sufficiently well to be placed under the care of relatives or friends.

The percentage proportion of recoveries on admissions was 37·66 (m., 30·89; f., 47·37), as against 44·27 (m., 44·89; f., 43·21) in the previous year, and 39·78 (m., 37·29; f., 43·45) in the average for all years since 1876.

The deaths numbered 289 (m., 209; f., 80), giving a percentage of deaths on the average number resident of 6·80 (m., 8·42; f., 4·52), and on the total number (general register) under care during the year of 5·63 (m., 6·93; f., 3·77). The corresponding percentages for the previous year were 6·94 (m., 7·19; f., 6·58) and 5·79 (m., 6·01; f., 5·42) respectively.

Not included in the above analysis are 1 male resident at the beginning of the year who had been sent for observation under Magistrates' order, and 62 (m., 41; f., 21) so received during the year. Of that number, 20 (m., 13; f., 7) were formally committed, 7 (m., 3; f., 4) were under observation at the end of the year, and 36 (m., 26; f., 10) after a short period of observation and treatment no longer needed oversight in a mental hospital.

Also not included are the voluntary boarders, of which class 26 (m., 12; f., 14) were resident at the beginning of the year, and 48 (m., 18; f., 30) were admitted during the year. Of the total, 35 (m., 13; f., 22) were discharged, 1 male and 2 females died, and 9 boarders (m., 5; f., 4) were transferred to the register of patients, leaving 27 (m., 11; f., 16) resident at the end of the year.

It is necessary, owing to frequent misconceptions when returns of individual institutions are contrasted, to point out that comparisons of relatively small numbers are very misleading, because percentages which on the surface differ fairly widely are substantially equal as a test of care and treatment when due allowance is made for contributory factors. Take, for example, the factors influencing the returns of recoveries. It will have been noted above that Magistrates occasionally remand patients to a mental hospital for care, observation, and safe keeping, pending the determination of an application for a reception order. The distribution of these patients is irregular, as is also the distribution of voluntary boarders. Of the patients sent for observation, 36 were probably saved admission under reception orders by being placed promptly under suitable care and treatment pending that procedure, delayed at first when improvement became manifest, and finally abandoned as unnecessary. Of the voluntary boarders, 35 were discharged recovered or greatly improved. These two classes furnished a recovery-rate of, roughly, 60 per cent., which is not credited to the institutions concerned, because the statistical tables deal only with persons admitted under reception orders. There are other factors also which cannot be gleaned from statistics, but among those that can it will be noted that Table IV, which deals with the duration of disorder on admission, demonstrates an unequal distribution between the institutions of acute and chronic cases. Then, if Tables III and V be contrasted, it will be seen that the proportion of recoveries is much lower than that of admissions up to the age of 15; that thereafter the reverse is the case to the age of 30; that then the proportions more or less balance for the next three decades; and, lastly, that there is a decidedly higher proportion of admissions after the age of 60 than of recoveries after that age. With small numbers different years will show differences in detail, but broadly these proportions are not far from the truth; and it should be added that certain mental disorders of greater or lesser curability are associated with age-periods. Turning to the individual institutions, it will be found that the distribution of favourable and unfavourable ages is unequal. Other factors might be reviewed in this connection, but enough has been said to indicate that grand totals should be the measure of our efficiency.

Reference was made to the number of patients admitted who were over 60 years of age. There were 160, and in 118 of these the principal assigned cause of insanity (Table XV) was senility—premature in some, but in others the ordinary decay of old age impairing the mental faculties. A large number of these old people merely needed a little oversight and nursing, and might well have spent the evening of their days at home, provided some one were at hand to perform dutiful and kindly offices. I am not going to make any comment on filial ingratitude—one does not know the actual state of things in this cottage or that house, and maybe the aged mentally infirm parent is parted with sorrowfully—but I consider it necessary to point out that many such patients are sent to us from Old People's Homes and Benevolent Institutions, and that in some of the cases thence received we have noted on admission symptoms which were the prelude of the final dissolution. We take over the care of this class, as indeed we must; it cannot be provided for entirely by home care or entirely in institutions under Charitable Aid Boards; but a certain amount of common-sense should be exercised with regard to those that can and those that cannot be cared for properly outside mental hospitals. It is useless to plead, "If doctors certify, then our responsibility ends." Of course, doctors will certify, and very properly so, if the authorities at the Home state they have no facilities for dealing with the case, but the responsibility of such authorities does not end there, because such institutions should provide facilities for dealing with ordinary physiological senile decay. It is not right that such patients should be filling our infirmary beds. The matter of providing special accommodation is under consideration now; but before entering upon the expenditure and accepting the policy involved one would like to know whether the charitable-aid institutions cannot carry out the nursing, care, and supervision of the aged who are mentally infirm; and, if they cannot, I am of opinion that the Boards should pay this Department for the maintenance of patients transferred from these institutions.