1904.

NEW ZEALAND.

HOMES FOR INEBRIATES

(REPORT ON THE).

Presented to both Houses of the General Assembly by Command of His Excellency.

The SUPERINTENDENT OF THE HOME FOR INEBRIATES at Orokonui, Waitati, to the INSPECTOR-GENERAL OF HOSPITALS, &c., Wellington.

SIR,— Orokonui Home, Waitati, 21st July, 1903.

I have the honour to submit my second report on the Home for Inebriates established at Orokonui.

The first patient came in May, 1902, and since then there have been admitted thirty-six men and twelve women. Of these, there have been discharged fifteen men and five women. In the case of any ordinary hospital it is usual to give a tabulated statement of the results of treatment under such headings as "Recovered," "Improved," "Not improved," "Died." Sufficient time has not yet elapsed to enable me to give any definite opinion as to recoveries; no patients have died; and I should say that, without exception, all have improved.

A properly regulated life, and abstinence from alcohol, quickly bring about a remarkable physical and mental improvement in alcoholics, but a change of this kind, if temporary, is obviously not the purpose for which such necessarily costly institutions are established. The question which the authorities will no doubt wish to have answered promptly is whether the Home is *curing* its patients, and, if so, in what proportion of cases. The egregious mistakes which have been frequently made by medical men in charge of newly established Homes for Inebriates, when they have essayed the *rôle* of prophecy, and undertaken to foretell how their patients would behave in the future, incline one to tread cautiously, if at all, in this path. The wish tends to be too much the father of the thought in such matters. There is no reason to doubt the sincerity or honesty of the physicians who thirty years ago announced confidently that they were curing over 60 per cent. of the patients submitting themselves to treatment in the Homes then established. The patients themselves, no doubt, said confidently that they were certainly cured, that they were new beings, that they had done with drink, and that all desire for it had left them for ever, just as they assert to-day, and it was hopefully assumed that the reformation would be permanent. It is generally supposed that during the last twenty years scientific means of treating alcoholism as a disease have been evolved, and it might be concluded, therefore, that statistics would show a marked advance in the recovery-rate, but this is unfortunately quite the converse of the truth. The more searchingly the results of the treatment of inebriates have been investigated, the more apparent it has become that high percentages of recoveries are not really attainable by any known means. Precise Government statistics, compiled and edited by responsible authorities, do not lend themselves to hopeful flights of the imagination. In the report for 1902 of Dr. Branthwaite, the Inspector under the English Inebriates Acts, we find that the estimated recovery-rate of patients admitted into licensed retreats in England is only 25 per cent.

These retreats are well-equipped special institutions, to which admission is purely voluntary, and the patients, who have to pay an average rate of £2 15s. a week, are the most hopeful class of persons who come under treatment. They may be assumed as a whole to recognise their failings, more or less, and the fact of their voluntarily subjecting themselves to treatment affords some evidence of a desire to amend. Dr. Branthwaite says, "For the sake of clearness it will be well to remind casual readers of the difference between the work of a *retreat* and that of a *reformatory*. On leaving the former we completely turn our back upon the principle of voluntary admission." Compulsory detention in State reformatories came into operation only with the passing of the Inebriates Acts, 1898 and 1899, and the results so far have been so unsatisfactory that most of the available articles on the subject are apologies or explanations dealing with universally recognised and acknowledged failure. Dr. Branthwaite tries to be hopeful, but does not venture to give a single figure in the way of statistics as to the "Results of treatment." Under this heading he says, "I do not propose this year to present any more definite statistics than those already shown in relation to licensing." However, what Dr. Branthwaite does say in relation to *licensing* is itself sufficient evidence of the most complete failure: " . . . . to secure the maintenance of improvement after release from sentence . . . . it was decided to permit the issue of a license to be at large as soon as any inmate gave evidence of recovery sufficient to make it appear reasonably possible that he would be able to keep from liquor and take care of himself. The granting of such a license permits residence out of the reformatory and resumption of the ordinary duties of life. The permit remains in force for the remainder of sentence, or so long as the inmate continues to refrain from the use of intoxicating liquor. Should he return to his drinking habits the license can be revoked, and the inmate compelled to return to the reformatory from which he was licensed. To

insure some control being exercised, and correct information being given to the reformatory-managers, some person is required to become responsible for the licensee whilst at liberty under these conditions, and to report monthly to the managers as to his behaviour. . . . . Licensing practically commenced with the year 1900. During 1900 licenses were freely given to inmates at the termination of nine months' residence, with the result that a large majority relapsed at once. . . . . It is probable, if all relapses during the first year of licensing could be ascertained, that the revocations from January to June would stand at about 80 per cent. . . . . The average term of detention before license is granted is now approximately eighteen months, and I agree with the managers of reformatories that any period short of that time, unless in very exceptional cases, is useless." It is quite certain that if 80 per cent. of the most hopeful cases, selected for licensing on account of their apparent recovery, relapsed within a very short time, little could be hoped in regard to the balance of patients not so selected. Further, it would be highly optimistic to assume that half of the 20 per cent. of licensees who withstood the immediate brunt of temptation, would remain sober long enough to entitle themselves to be classed as "recoveries." All statistics giving the results of after-study and careful following-up of patients show that a large proportion of those whose drinking habits have been temporarily arrested succumb, especially during the first year of outside life, and in a diminishing ratio as the years go on. Practically speaking, it is evident that so far the forced reformatory treatment of inebriates in England has only been redeemed from absolute failure by a potential percentage of recoveries which is altogether insignificant. In the face of the official reports, it would be sanguine to expect an average recovery-rate under past conditions of more than 5 per cent., though it is possible that with the more general adoption of three years' detention somewhat better results may be attainable. Curiously enough, the number of patients under care in voluntary retreats in England for the year 1901 was practically the same as the number in State reformatories—viz., 433 in the former and 436 in the latter. Roughly speaking, then, we may estimate that 869 alcoholics under treatment in institutions in England at the end of 1901, 108 retreat patients and 22 reformatory patients would probably recover, or an average of 15 per cent. of all patients under treatment.

Since within this colony we have had as yet no basis of experience, either in respect to numbers or time, which would enable us to form any independent estimate as to the probable results of the treatment of inebriates in special institutions, it is obviously desirable to ascertain how far the rough approximate statistics arrived at for England would form a safe guide here. The problem is analogous to the problem of adapting Home life-insurance tables to colonial conditions, the results of English experiences not being directly applicable without making allowance for local divergences. The main disturbing factors are—firstly, *a marked difference in the character of the populations of the two countries.* We have nothing corresponding to the large profligate and drunken population of Old-world cities—no submerged *tenth*—and there is in New Zealand no lower-class labouring-population which can be identified in drinking habits with that class in England. Further, the proportion of women drunkards is much less here than at Home, and Mr. Shadwell's statement in his book, "Drink, Temperance, and Legislation," that "women tend to monopolize the field of habitual inebriety among the working-classes," could not be applied here; nor would a reformatory if established in this colony have to provide accommodation in the proportion of fifteen women to every two men, as is the case at Home. The patients detained in English inebriate reformatories at the end of 1901 consisted of 385 women and fifty-one men. Of the voluntary patients in retreats, on the other hand, there were more men than women—viz., 247 men to 186 women. The bearing of these facts on statistics is important, because the prognosis in the case of women is much less favourable than in the case of men. The second important point of divergence between English and colonial conditions is *the difference between the English and New Zealand Inebriates Acts.* This is rendered clear in the following table, adapted from an article on the working of the English Acts by Dr. William Cotton:—

THE LEGISLATIVE CLASSIFICATION OF THE HABITUAL DRUNKARD AS REGARDS INEBRIATES INSTITUTIONS.

Institution or Part of Institution.	Class of Patient or Nature of Case.	Special Act of Parliament or Part thereof.
	ENGLISH ACTS.	
1. Retreat licensed under the Act	(*a.*) Habitual drunkard voluntarily applying under the Act, and duly attested by a Justice of the Peace	(1.) "Habitual Drunkards Act, 1879." (2.) "Inebriates Act, 1888." (3.) "Inebriates Act, 1898."
2. State inebriate reformatory, or 3. Certified inebriate reformatory	(*b.*) Habitual drunkard convicted of an offence punishable with imprisonment or penal servitude	(4.) "Inebriates Act, 1898."
	(*c.*) Habitual drunkard four times convicted of drunkenness, three of these convictions being within a year preceding date of fourth offence	(5.) "Inebriates Act, 1899."
	NEW ZEALAND ACTS.	
Special quarter in lunatic asylum	(*a.*) Habitual drunkard voluntarily applying to Judge of Supreme Court for committal	"Lunatics Act, 1882," "habitual drunkard" section.
	(*b.*) Habitual drunkard committed by Judge on the representation of relation or friend	
Inebriates institution proclaimed under the Act	(*c.*) Inebriate voluntarily applying to Magistrate may be committed to institutions for inebriates	"Inebriates Act, 1898."
	(*d.*) Inebriates may be committed to institutions without giving their assent, if Magistrate satisfied, on (1) application made by relations or friends; (2) proof made otherwise that person is an "inebriate," Magistrate having authority to call upon such person to show why he should not be committed (no need of further proof in case of prohibited person).	

It will be seen that the New Zealand Act of 1898 provides for the admission of all persons who could be admitted under the various English Acts, and that in addition it provides for the *compulsory* detention of habitual drunkards who may never have been "convicted" on account of drunkenness or any other offence.

The introduction of this power to *force* treatment in an institution on any inebriate for his drunken habits alone, quite apart from the question of his having actually stood in the dock, entirely changes the meaning of the term "voluntary patient." The majority of the patients admitted to the Orokonui Home on their own applications, and therefore claiming to be technically considered as "voluntary inmates," have really been forced in by their friends. Seeing that they could not escape from the law, they have made a virtue of necessity and applied for their own committal. They have entered the Home nominally of their own volition, but really under the shadow of compulsion. The following is as close an approximation as we can make towards a statistical classification of the headings under which the forty-eight patients who have entered the Home should be placed :—

True Voluntary Patients.		Nominally Voluntary Patients who have come in under the Shadow of Compulsion.		Non-voluntary Patients.		Total.	
Male.	Female.	Male.	Female.	Male.	Female.	Male.	Female.
7	...	10	3	19	9	36	12

The first class corresponds fairly closely to the English "retreat" patients, but is not exactly identical, because absolutely destitute persons can be voluntarily committed in New Zealand, and this has been done in several cases. By this means a person against whom there had been repeated convictions in the Courts, and who would have been classed and treated as a reformatory case in England, gained admission to our institution as a patient on his own volition. In the second and third classes we have a certain proportion of patients corresponding to the English reformatory class, but even here the majority belong to a special class not provided for by the English Acts; and as regards prospect of recovery, these may be regarded on the whole as standing midway between the English "retreat" and "reformatory" patients. Few belong to what would be ordinarily understood as a criminal class, but they are mostly irredeemable drunkards who do not recognise, and cannot be *brought* to adequately recognise, the gravity of their condition or the misery it entails on their families, are not anxious to reform or to be reformed, and decidedly resent being compelled to forego their freedom for a time in order to give themselves a chance of restoration to physical and moral health.

It has been proposed repeatedly in England, especially during the last ten years, to make legislative provision for the compulsory detention of this class, but it has as often been pointed out how very hopeless any form of treatment must be without the sanction and help of the patient. Theoretically it has seemed arguable that, provided the person could be forcibly kept in healthy physical surroundings, and in a good moral atmosphere, and made to lead a regular, active life, apart from access to stimulants, it might be hoped to win him in a short time to see the error of his past ways, and thus to secure his hearty co-operation for the rest of the time during which he might need to remain under treatment. No doubt there are a few such cases, but they are very few. More or less complete restoration of bodily health may be confidently reckoned on. Usually there is improvement in the will-power and general mental faculties, and some return of moral sense; but, with few exceptions, a careful study of the case affords conclusive evidence of organic brain-changes, which place a limit on the progress which can be made in regard to both the mind and the moral outlook of the patient. There is no use in shutting our eyes to the fact that, when the delicate processes of the highest nerve-cells have been structurally destroyed and replaced by lower tissues, we cannot hope that we shall ever have the power of fully restoring the functions associated with the regions of the brain so involved. We might as well expect to obliterate an old scar on the surface of the body and restore its glands and functions without grafting on new tissue; and brain-tissue does not admit of replacement by grafting. Before the days when the microscope, aided by modern histological methods, was to reveal the intimate structure of the brain, and the ravages made by habitual drinking in the regions of the most specialised, the most recently evolved, and the highest ramifications and extensions of the nerve-tendrils peculiar to man, Dr. Moxon, the greatest of the earlier English pathologists, had said, "When the sot has descended, through his chosen course of imbecility, to the dead-house, morbid anatomy would tell you at the *post-mortem* that the once delicate filmy texture which, when he was young, had surrounded, like a pure atmosphere, every fibre and tube of his mechanism, making him lithe and supple, has now become rather a dense fog than a pure atmosphere—dense stuff which, instead of lubricating, has closed in upon and crushed out of existence more and more of the fibres and tubes, especially in the brain and liver . . . . and morbid anatomy would give evidence that such was the state of the drunkard long before he died. So that in vain you get him to sign the pledge. He signs too easily, because his brain is shrunken, and therefore he cannot reflect. And he breaks his pledge immediately, because his brain is shrunken and its membranes are thick, and therefore he has no continuity of purpose or will."

It needed but the most superficial knowledge of the pathology of the brain to enable one to say at once, of a certain proportion of the cases committed to Orokonui, that their brains were already in various stages of the irreparable structural degeneration described by Dr. Moxon. One patient

was absolutely demented, and had to be transferred forthwith to Seacliff; another was far gone in incurable dementia, having almost no memory, and a degree of general enfeeblement and perversion of the mental faculties which constituted her a borderland case. Several showed lesser degrees of similar mental impairment verging on dementia. The purposive faculties, will-power, initiative, discipline, and the moral sense cannot be said to be unimpaired in any chronic alcoholic*; but several patients were committed to the Homes whose defects in these directions—especially in regard to moral sense—were so extreme, and so long and fixedly established, as to render recovery out of the question. It was the conviction that such obviously hopeless cases would tend to be committed that made me propose to the authorities early last year, before the Home was opened, to restrict the admissions at Orokonui to cases certified as potentially curable by two medical men. I am pleased to see that an amending Act is now before Parliament, making provision for such certificates. There is another class of patient who should certainly not be committed to special institutions for inebriates—viz., any patient suffering from serious communicable disease. Two such patients—both phthisical—had to be discharged from the Home on that account, and it is highly desirable that the amended Act should prevent such committals in future.

I may revert now to the question of estimated prognosis. I have pointed out that in England half the cases under treatment are voluntary patients. When it is considered that at Orokonui up to the present time only one-seventh of the patients have themselves voluntarily come for treatment, and that this small fraction embraced one absolutely destitute person who was virtually suffering from moral insanity, and only sought the shelter of the Home as a refuge, it will be realised that, on the basis of statistics arrived at from English experience, we have no ground for expecting a recovery-rate of more than 15 per cent. The prognosis would, indeed, be rather less than 15 per cent. of recoveries if we calculated on the English basis of an estimated 25 per cent. for voluntary patients, and assumed that our forced inmates would recover in one-half of that ratio. I am, of course, aware that such figures will not be generally acceptable, but they convey the truth.

The optimistic professions of Dr. Norman Kerr and many interested "experts," supported by the indorsements of some well-meaning philanthropists, have created the erroneous idea that, as Dr. Kerr says, "inebriety is a disease as curable as most other diseases." Dr. Urquhart, in his presidential address before the British Medico-Psychological Association, said, when speaking on this subject, "That is so far from being even approximately true in my experience that I am not surprised to find in his (Dr. Kerr's) interminable list of 'remedies' but one short sentence to the effect that it is 'the great point to have a healthy outlet in energetic work of some kind,' regarding which 'a word of caution as to moderation will not be amiss.' In all his hundred-and-odd pages on treatment, only this and nothing more . . . . The hospitalisation of the drunkard is, after all, a late remedy and doubtful. We have a larger hope in anticipating, and so frustrating, habits of vice or disease. The true statesman fulfils his duties in formulating precautionary measures not less than in devising the reformatory treatment now under review."

But the easy optimism of such a writer as Dr. Kerr has had little effect on the public mind, compared with the persistent advertisements of the proprietors of so-called "cures"—whom, by the way, Dr. Kerr unsparingly condemns. In our intercourse with the patients at Orokonui and their friends, we have found how implicitly these advertisements are believed, and it must be confessed that they are specious enough to deceive any one not directly conversant with the truth. The worst type is the illustrated magazine advertisement—such as we find, for instance, in the April number of *Pearson's Magazine*. Our attention was drawn to this by one of the patients, who said, "There, now, that's the kind of cure I believe in." In the front of the magazine is the ordinary full-page advertisement of the "Keeley cure," with a portrait of the "inventor." The only point worthy of remark here is the announcement that the patients "go of their own free will to the Keeley Institute, or they are not admitted. If they do not wish to be cured, the Institute will have none of them." In other words, the Keeley cure is only for the hopeful minority.

The direct advertisement is, however, comparatively harmless. The most credulous people have some hesitation in accepting as true all the wonderful things that it may pay a man to have printed concerning himself and his achievements. It is the *indirect* advertisement which proves so universally convincing, and we find this incorporated in the text of the magazine in question in the form of an article communicated by the Rev. Canon Fleming under the heading "The Problem of Inebriety: Is there a Cure?" There is nothing to show whether such an article is directly paid for by the Institute as an advertisement or not, but one can form one's own conclusion as to whether the magazines which accept such matter would accept it if they were not fully paid for what does appear among their advertisements. There is no reason to question the *bona fides* of the reverend canon. Indeed, it is the apparent honesty and guilelessness of his statements which constitute their chief value from a commercial point of view. His portrait as he appeared "in his robes worn at the coronation" as "Canon of York, and Chaplain in Ordinary to His Majesty the

* Some authorities (and others who are not authorities) have recently objected that well-marked cases of drunkenness do occur without any great impairment of the moral sense. We should be very slow to accept any such statement. The fact is that physicians are not very well practised in the investigation of moral facts. . . . . In the huge majority of cases there is no difficulty at all. Most drunkards are flagrantly immoral, many of them criminal. The difficulty only occurs in the case of a very few men and women, whose drunkenness is of an exceptional kind. In particular there may be some difficulty in discerning the degradation in moral function in periodic drunkards who emerge from their occasional spells of intoxication with remorseful tears and pious promises. No one need doubt the sincerity of these most unfortunate backsliders; but before we can admit that they are an exception to the general rule that drunkenness is a disease essentially of the moral functions, some one must perform that most difficult and unlikely task of proving that they have as clear a judgment in moral questions, as elevated moral sentiments, and as resolute moral purposes, as if they had never given way to the vice which occasionally overcomes them. The most that can be said of them is that their drunkenness does not have a very obvious influence upon their character, because it is intermitting and allows of intervals of regeneration of the functions which have been assailed.—"Vice and Insanity," by Dr. George Wilson. Macmillan and Co., 1899.

King," seems to convey a more than human sanction to the assertions which he ventures to make regarding the essential nature of inebriety and the marvellous "cures" of which he claims to have been the witness. I will now consider in detail some of the canon's leading statements.

"The Problem of Inebriety: Is There a Cure?" By the Rev. Canon Fleming, Vicar of St. Michael's, Chester Square; Canon of York; Chaplain in Ordinary to His Majesty the King.

"After years of study he (Dr. Keeley) found a basis for the remedy in chloride of gold and sodium, and in 1880 opened his famous Institute. In a very short time, so wonderful were the results of the treatment, that there were seldom less than 1,000 persons undergoing the cure at the same time. Branches were established, and since that time more than 500,000 patients have undergone treatment for drink and drug addictions, and the number is increasing at the rate of 5,000 a month. . . . .

". . . . The patients come in all states of mind, many hopelessly intoxicated, others sober—which is the better way. One man, I remember, arrived on the very day when he had been released from nine months' durance in an Inebriates' Home. His first act on leaving it was to get drunk. In this state he was found by his brother, who took him straightway to the Institute, then in Kensington, where his disease was cured within four weeks. His descriptions of his cravings for drink whilst he was in the home were piteous to hear. . . . . At first the patients are allowed to take whisky or their favourite drugs as they please. The whisky, which is of the very best quality, is put up in special flasks. . . . . One by one each patient, graded according to his case, receives a painless injection in the left arm. Then the patient is given a bottle of medicine, which he must take every two hours during the day and evening. This is the whole treatment. Simple as it is, the results are instantaneous almost, and have furnished 500,000 living witnesses to prove that drunkenness can be cured." It is interesting to note here the thoroughness of the faith underlying the canon's advocacy. He leaves no room for any backsliding among the half-million persons he alleges to have been treated; they are all cured; and he has no doubts concerning anything the managers of the Institute may see fit to say or do. "I would recommend all who are interested to apply for the reports issued by the Institute. I can vouch for the truth of all cases in these reports. . . . . I am always ready to give all information." Even the precise *address* is not forgotten. "The Institute in London is now established in fine premises at 8 and 9, West Bolton Gardens, Old Brompton Road, S.W."

"What Keeley taught, as I understand him, was that the drunkard, having once become a drunkard, is no more responsible for drinking than a man is for having fever when poisoned by malaria. . . . . Alcohol, in fact, once the disease has been established, is a necessity. . . . . *A Government may keep the drunkard from drink, but it cannot prevent the craving for drink.* The longer a man is kept in an Inebriate Home the more he craves for drink."

Similar articles by Canon Fleming have appeared recently in the *Windsor* and other magazines.

In 1892 Dr. Keeley, of Chicago, was alive, and his "cure" had not entirely passed into the hands of commercial companies. He visited London and tried to get a syndicate formed to raise £150,000 in order to purchase the right to use his "gold cure" in England. The nostrum having been analysed, a meeting of the "Society for the Study of Inebriety" was held in London, and the following resolution was passed, "That this meeting, having been informed by a competent London analyst, who has made a special analysis, that the alleged 'bichloride-of-gold cure' shows no trace of gold or chlorides, and contains 27·55 per cent. of alcohol, condemns unreservedly the prescription of such an intoxicating preparation to an inebriate."

The Church of England Temperance Society, attracted by Dr. Keeley's vaunted successes (95 per cent. of cures) and by the statement contained in his pamphlet that "the patient need make no effort, the cure follows the taking with the same certainty that night follows day," determined to hold a meeting under the presidency of Bishop Barry to hear an address on "the gold cure." That meeting was adjourned *sine die*, and the Church has never allied itself with Dr. Keeley or his "gold cure." Through its temperance society, however, it has shown its confidence in the treatment of inebriates by segregation for long periods in properly conducted homes. The latest official report of the Inspector (Dr. Branthwaite), dated 1902, says, "Greater interest centres in the generally improved tone and character of the existing institutions, and in the addition to the list of some excellent retreats conducted by philanthropic bodies. Ten years ago only two licensed retreats were conducted by societies whose object was philanthropy, not financial gain. To-day there are twelve such institutions duly licensed and in active operation; more than half, in fact, of the total number of retreats. . . . . By virtue of numbers, the Church of England Temperance Society takes an easy lead with four excellent retreats—viz., Ellison Lodge (London), Hancox (Battle, Sussex), Corngreaves Hall (Birmingham), Hamond Lodge (Lynn); besides which there is the 'Spelthorne St. Mary Retreat' under the Anglican Sisterhood. The latest-established is Hamond Lodge." In September, 1899, a meeting was held consisting of representatives of the dioceses of Ely, Lincoln, Norwich, Oxford, and Peterborough, and it was then unanimously decided to co-operate in the establishment of a Home for the treatment of inebriates on the same lines as Ellison Lodge.

Extracts from the Special Reports for 1901 of Retreats established by the Church of England Temperance Society.

Ellison Lodge.—"To obtain a good hope of a permanently satisfactory result, all patients, except a very few exceptional cases, should remain in the Home for at least fifteen months or two years, or longer. But for the most part they themselves or their relatives and friends think they are cured far too soon. At the point when the good influence, training, and discipline are just beginning to take effect, and a longer stay would be so beneficial, they desire to leave, and they go out totally unfit to face their old temptation, which so often proves too strong for them."

Corngreaves Hall Retreat.—"It has become clear that short periods of detention are useless, and the Cases Committee has firmly declined to accept patients who refuse to legally bind themselves to remain in the Home for at least twelve months, and preference is now given to those who are willing to enter for two years."

The failure of the Anglican Church to avail itself of the "Keeley cure" after giving the matter careful consideration over ten years ago, coupled with the fact that the Church has since gone to great expense in establishing Homes in which long periods of detention are advocated, is surely the best answer to Canon Fleming's statement that "the longer a man is kept in an Inebriate Home the more he craves for drink." But I shall submit other evidence.

Report of Departmental Parliamentary Committee on Inebriates, &c., 1895.

"*The Theory of the Cure of Inebriety.*—The opinion of the most eminent medical authorities—many of whom, such as Professor Gardner, Sir Douglas Maclagan, Dr. Yellowlees, Dr. Clouston, Dr. Urquhart, Dr. Nicholson, Dr. Norman Kerr, Sir James Crichton-Browne, and others, gave evidence before us—is unanimous in bearing out the popular opinion that the effect of inebriety is to destroy the will-power of the victim in a manner which can only be remedied by a prolonged abstinence from drink—an abstinence which can, in the great majority of cases, only be insured by effective physical control, supplemented for restorative purposes by appropriate medical treatment. This view of the subject is advanced not only by the medical gentlemen whom we examined, but practically by the whole medical profession; and the reasons given in support of it have sufficed not only to carry conviction to our minds, but to convince the Select Committee on Habitual Drunkards of 1872, and the Departmental Committee of 1892. We content ourselves by referring to the evidence of the gentlemen whose names we have quoted for particulars of the technical details of what from a psychological and physiological point of view is an extremely interesting problem, and at once proceed to the question of how best practically to deal with the matter."

"The Disease of Inebriety." Published by the American Association for the Study and Cure of Inebriety.

"The first condition of cure and reformation is abstinence. The patient is being poisoned, and the poisoning must be stopped. . . . . Abstinence must be absolute, and on no plea of fashion, of physic, or of religion, ought the smallest quantity of an intoxicant be put to the lips to an alcoholic slave. . . . . The second condition of cure is to ascertain the predisposing and exciting causes of inebriety, and to endeavour to remove these causes. . . . . The third condition of cure is to restore the physical and mental tone. This can be done by appropriate medical treatment, by fresh air and exercise, by nourishing and digestible food given to reconstruct healthy bodily tissue and brain-cell, aided by intellectual, educational, and other influences. Nowhere can these conditions of cure be so effectually carried out as in an asylum (Inebriate Home), where the unfortunate victim of drink is placed in quarantine. . . . . ."

The medical treatment recommended in this book of some four hundred pages, published by an association established in 1870, composed of physicians and others interested in the cure of inebriety as a disease, and in the scientific study of the drink problem, does not mention as worthy of consideration any specific drug whatever. The course indicated is essentially hygienic, and the only reference to drugs is the indication that the ordinary tonics, sedatives, salines, &c., should be used where the condition of the patient shows that they would aid in restoring health. Our experience at Orokonui and elsewhere is entirely in accord with these views, and it is impossible to characterize too scathingly Canon Fleming's statement that "the longer a man is kept in an Inebriate Home the more he craves for drink." The tendency is absolutely in the opposite direction. There are not 5 per cent. of the average chronic inebriates who, at the end of a month's total abstinence and healthy regular living, appear to have any special desire for alcoholic drinks, and a certain proportion have an actual distaste for them.

This fact, indeed, gives rise to one of the greatest difficulties we have to contend with in the systematic treatment of the patient. Feeling himself well and capable again, and experiencing no desire for drink, he assumes that he is "cured," and is not open to reason on the subject. He writes glowingly to his relations, who, though sceptical at first, tend soon to yield to his reiterated assertions. In a large proportion of cases the relations become satisfied of the patient's permanent amendment, and after a few personal interviews nothing will convince them to the contrary, and they join in bringing pressure to bear upon the authorities for an immediate rescission of the committal order. This unfortunate readiness of friends to accept the *feelings* and *statements* of inebriate patients as reliable guides is due to an entire ignorance of the fundamental nature of alcoholism and of the ordinary results of simple abstinence and healthy living, coupled with the ingrained conviction that a "craving" for drink, as a distinct entity, is characteristic of chronic alcoholism.

In reality the term "crave" or "craving" is only applicable to a very minute percentage of alcoholics—viz., those suffering from what is generally recognised as a form of impulsive insanity—viz., dipsomania. Apart from such patients, a craving for drink is characteristic only of a state induced by recent drinking—a state which quickly disappears with the elimination of alcohol from the system and the restoration of health. At one time I was inclined to regard the rapid disappearance of the desire for drink which takes place in institutions as due largely to *suggestion*, because the patients often assumed that they had been cured by the specific character of the simplest ordinary medicines which had been prescribed for them. However, it was so often impossible to impress the patient with any sense of the active part he was expected to play in his own regeneration, so long as he assumed that he was being cured of his disease by means of drugs, that I came to the conclusion it was better to be frank on this matter and to announce the actual basis of treatment. Since then from time to time we have explained to the patients how dependent the will-power is upon a healthy active state of the body; and how much it can be strengthened by the regular systematic

ordering of life and habits, by carrying out one's appointed duty when one would prefer to be doing something else, and by not always following one's tendencies and choosing the lines of least resistance, even in the pursuit of pleasure. But this course of procedure has made no apparent difference as regards the "drink crave," which has still remained conspicuously absent from our patients. Recently we took a careful census of the population at Orokonui on this subject, and made a note of the idiosyncrasies of each case, examining the patients separately when they were scattered about the estate at work. The inebriate is notoriously communicative and expansive on the matter of his subjective sensations, though from a psychological point of view the field is somewhat limited. In the matter of the "drink appetite," the variation in the field of subjective experience in different individuals is even more circumscribed and characteristic than are the reptilian hallucinations of delirium tremens. Nothing could, indeed, be more stereotyped than the accounts we received from the various individuals as to their impulsions to drink. This was made more striking by examining some twenty-five persons in succession, and noting shortly what each one actually said. Substantially it was this in composite effect: "I feel no desire for liquor now. I am not even troubled with any thirst, and don't drink more than I always did. I felt no craving for liquor after the first few days" (or "the first week," or "the first few weeks"). "But you don't mean to tell me that you never feel as if you longed for a glass of something?" "No; really, I never feel that way now, and have not done so since the first week. I would have taken it then if I could have got it." "Then, there is no such thing with you as a craving for drink?" "No; not when I am away from liquor." "How do you mean?" "Well, you see, it 's this way. You get into company, and before you know where you are you've taken a glass, then you take some more, and then you're done. It 's when you wake up the next morning that you have a crave. You can't eat, you feel a sinking, and you must have it then; the drink sets you up, but you must go on." "But you must have a crave or you wouldn't take the first glass?" "Not at all. It isn't the drink. I don't really care for the drink itself, and I know I am always better without it." "You don't know why you take it?" "It 's the company I suppose."

In a minority of cases the "company" is not mentioned, but the patient speaks of feeling the "sinking" in the pit of the stomach, and needing something to "lift you up." This does not come over him when living regularly and under treatment; and on critical examination one finds it to be clearly the outcome of dyspepsia and general *malaise* induced by careless living. De Quincey, writing sixty years ago, said, "Past counting are the victims of alcohol that, having by past efforts emancipated themselves for a season, are violently forced into relapsing by the nervous irritation of demoniac cookery. Unhappily for *them*, the horrors of indigestion are relieved for the moment, however ultimately strengthened by strong liquors; the relief is immediate. . . . This is the capital rock and stumbling-block in the path of him who is hurrying back to the camps of temperance."

Since taking our "crave" census my attention has been directed to a paper read by Dr. George Wilson in 1898, at the annual meeting of the Medico-Psychological Association, on "Mismanagement of Drunkards." Dr. Wilson's statements have a special weight not only on account of his extensive experience in the special study and treatment of inebriates, but because he is the most original thinker and writer in our language on the medical and psychological aspects of inebriety. He says, "Another plea which drunkards use with great effect, in Scotland at least, is what I have no hesitation in calling the myth of the 'crave' for alcohol. I know no better illustration of the evil of what one may call the gossip about medical facts, for which the public are so greedy. Cases of a real 'crave' have, of course, been described, and are a very interesting fact. But ever since some one wrote of the man who cut off his finger in order to get the brandy which he knew would be prescribed, and of the schoolboy who wore his fingers to the bone in midnight excavations towards his master's cellar, nearly every drunkard in Scotland has been credited with a crave. For my part, I have never seen a case which exhibited what I would dignify by the name of an alcoholic crave. That it exists there can be no doubt; but its frequency has been enormously exaggerated. Very many alcoholic cases suffer from a gastritis which their habits have induced, and the discomfort of which they call a crave for drink; others have induced a disorder of the lower nervous mechanisms, which gives rise to a want of the normal feeling of well being. Let us, then, teach that a crave is really nothing to boast of, that only ill-constituted persons and those whom showmen call freaks ever have it."

Out of the forty-eight patients who have been under treatment at Orokonui, only two have shown, after the first month, manifestations of a "craving" for drink while at the Home. One of these has been for some twenty years a typical "repeater," against whom there have been over 130 police-court convictions. The other case is of somewhat similar character, and he has shown his tendency by escaping from the Home on several occasions and getting drunk. Both these patients recognise and admit the attraction which liquor has for them from time to time, quite apart from the question of their having recently taken any.

I have thought it necessary to dwell at length on the question of so-called "crave" because practically all the secret "cures" which are at present in use in England, and some of which have been given a fairly extensive trial in the colonies, base their claims on the influence they are supposed to exercise in annihilating the craving for stimulants and in strengthening the will-power.

The matter of secret "cures" is recognised at Home as one of such importance that numerous investigations have been carried out by religious and philanthropic bodies, by Government, and by the medical profession. The latest research was made last year by the British Medical Association, which, after investigating the claims of the seven "remedies" having the greatest vogue, came to the conclusion that none of them were worthy of support. At the head of the list as regards expense come the Keeley and Hagey "cures," the former costing from £35 to £40 for four weeks', and the latter twenty-five to thirty guineas for three weeks' treatment. The "Tyson cure" (a vegetable remedy) is specially interesting, because it appears, like the Keeley

cure, to have survived and flourished in spite of having been shown long ago to be unworthy of consideration, though the fact has evidently escaped the attention of the British Medical Association. I find in the report of the Departmental Parliamentary Committee on Inebriates for 1895, under the heading "Secret Cures," an account of a fair trial made by a committee appointed by the Good Templars of Dundee, under the superintendence of Dr. Tyson's London agent: "Nineteen patients went through the twenty-one-days course. The result at first seemed very satisfactory, and the committee reported on 2nd February 'that the statements made by Dr. Tyson up to the close of the treatment were fully justified.' The committee followed up the cases. By the 11th of October, or eight months and a half after the conclusion of the treatment, all but four had relapsed into their old habits. Of the fifteen who had done so, however, it was asserted 'that in no case had the lapses been due to a return of the craving.' They had all resumed drinking because they wanted to join their old friends." The parliamentary committee reported, "Everything we have heard leads us to believe that no reliance whatever is to be placed upon these secret cures, which in our opinion are absolutely worthless." In spite of this report it appears that some forty thousand persons have been treated by the Tyson cure.

In the British Medical Association's report special stress is laid upon the absence of anything worthy of the name of statistics. Claim is laid to curing from 80 to 90 per cent. of patients, but this is supported merely by "testimony of cure" offered by particular individuals, without any evidence as to numbers. There is no reason whatever to doubt the sincerity or genuineness of the testimony so far as it goes; but the extraordinary fact is that it should be accepted by any one as having any weight in supporting generalised statistics. In the article I have already quoted by Canon Fleming appears the following: "But the most interesting part of my committee-work comes when it is time to hold the annual meeting, and when ladies and gentlemen who have been through the treatment assemble before a small Board 'to testify.' It is like one of those missionary meetings at which converts come forward to declare their conversion." Before the days when the treatment of alcoholism had become the happy hunting-ground of the quack, it would have been quite easy in any town in New Zealand to pick out several genuine cases of men who, after having been heavy drinkers for a number of years, had managed to master their failing. It would be strange, indeed, if among the half-million drinkers who are alleged to have tried to give up their habit, and sought the aid of the Keeley nostrum in the Northern Hemisphere, there could not be found a considerable number who had succeeded.

Some years ago a wave of "specific treatment" for inebriety passed over this colony, and a large number of persons submitted themselves to be cured. A considerable number of the patients sent to Orokonui had been so treated, and I know from them and from reliable medical testimony how very few throughout the whole country kept well after the first year. Dr. Colquhoun, the lecturer on the Practice of Medicine in our University, who has given special attention to the subject of inebriety, informed me a year ago that out of the large number of patients treated in Dunedin there was, so far as he could ascertain, only one patient who had not relapsed.

The aspect of the treatment of inebriety upon which I have been dwelling would be of comparatively little practical importance, so far as the Government institution is concerned, were it not for the fact that, as I have already stated, public opinion has been almost entirely built, directly or indirectly, upon misleading statements of advertising quacks. We have to contend against the degenerate credulity of the day, the tendency to unreasoningly welcome anything that may happen to be new, without pausing to inquire whether it be good or even possible. As Max Nordau says, "There is a sound of rending in every tradition . . . . Views that have hitherto governed minds are dead . . . . Where a market vendor sets up his booth and claims to give an answer, where a fool or a knave suddenly begins to prophesy in verse or prose, in sound or colour, or professes to practise his art otherwise than his predecessors or competitors, there gathers a great concourse."

Every short cut to salvation for drunkards, if loudly enough proclaimed, is thoughtlessly welcomed by thousands. The body and soul of man have been lowered, in the popular conception, to the level of a test-tube and its contents in the hands of a chemist; and humanity has brought itself to believe that the mind and the will can be strengthened and extended by the direct and specific action of drugs upon the cells of the brain. We have every reason to believe that this will never be the case, that "evolution while you wait" will never be available at the bidding of any charlatan. We may be thankful that there is still some room for human choice and effort, that the "Pilgrim's Progress" is not entirely obsolete. As Dr. Urquhart says,* "The latest dictate of science is in confirmation of the wisdom of the ages. If we grant that the will traverses the cells and fibres of the brain along paths that are capable of auto-development, and that normal man is so endowed with mental powers as to be in truth 'the captain of his soul,' verily it is our duty to avoid ignoble thought, and to entertain high purposes. . . . Not least upon us is laid the apostolic injunction to think on those things which are of good report. Perennial is the command; perennial are the rewards, written large upon individual character, and upon the lives of those intrusted to our care."

This, surely, is the point of view which we should impress upon our inebriate patients—that their ultimate redemption from vice and disease must rest largely with themselves, and that while in the Home they must be equipping themselves in body, mind, and morals for an outside environment full of pitfalls and temptations. As physicians, we are called upon to restore them to as perfect health as our powers and resources can insure, and to give them the best advice and counsel as to the conduct of life while under our immediate care and after leaving the institution. These things we have endeavoured to do throughout, but we have found a great stumbling-block in the convictions which have been formed by the majority of the patients before they reach us. They say, "Give

* The Presidential Address delivered at the Annual Meeting of the Medico-Psychological Association, July, 1898, by A. R. Urquhart, M.D., F.R.C.P.E.

us something to *swallow*, something to *inject*; not something to *do*; not something which will need the exercise of patience, effort, self-restraint, and, perhaps, even an element of self-sacrifice for a time."

The following letter, which I was impelled to write, explains itself, and will suffice to illustrate the kind of difficulty we have had to contend with at Orokonui on account of the erroneous preconceptions both of patients and their friends. The letter has been altered merely in a few unessential details, in order to prevent identification :—

SIR,— Orokonui Home, Waitati, ———, 1903.

You ask me to pardon the liberty you take in writing as you do concerning your brother, and I do so freely, in spite of all that your letter implies.

Your affection for your brother has obviously blinded you to all other considerations, and you have accepted unquestioningly what he has seen fit to say concerning his treatment at Orokonui. It does not seem to have occurred to you that the statements contained in his two letters might be without foundation, and I assume from this that you have not realised how absolutely depraved the moral nature frequently becomes in alcoholics, especially in regard to truthfulness. It is painful to have to enforce upon you the gravity of the malady from which Mr. ——— suffers, but it is my duty to let you know that there is no condition known to us as physicians which is liable to so entirely pervert a human being's sense of truth and honour, and to so completely strip him of altruistic qualities, as chronic alcoholism. If there is one effect of alcohol upon the moral nature which stands out more prominently than another, it is that in a certain proportion of cases the quality of truthfulness is absolutely blotted out. There is no form or degree of deceit and lying to which such an alcoholic will not resort in order to enlist sympathy, to convey to all who will hear him his sense of the wrong or persecution which he has endured, and to bring about the removal of any form of regulation or restriction to which his friends may have been compelled to subject him on his own behalf and to save him from himself. I am surprised that you should be in entire ignorance of the fact that no reliance can be placed on your brother's statements. From the tone in which you have written, on the bare authority of his letters, I can only assume that you have not been closely associated with him for a long time, and that the change which has come over his moral nature has not dawned upon you.

You appear to have no doubts on the following points, viz. :—

1. The Orokonui Home is "nothing but a jail," and Mr. ——— is "simply shut up so that he cannot get drink."

2. He has been entirely neglected by myself and others since admission, and "has had no medicine of any kind given to him."

3. He is set to do work for which he is unfit, and "has to work hard digging up scrub."

4. "He is feeling his position acutely, and his mental depression is something dreadful."

5. "He says he cannot sleep at night, his brain is going night and day," and you are afraid that if he cannot be got to sleep, "he will break down altogether."

Mr. ——— arrived at Orokonui at night by the express train. I saw him the next day, and spent fully an hour with him on the day following, investigating thoroughly his state of mind and body.

The following are extracts from the report in the official case-book: "When patient arrived at the Home he was too intoxicated to get upstairs without help, and admitted that he had drunk a flask of whisky on the journey." He was given a laxative and a drink of hot milk-and-water, and after having a hot bath was put to bed, but "he was very restless and sleepless all night. For an hour or so he kept calling out for brandy and soda; thought he was driving sheep, and kept whistling and calling to his dogs. There was no vomiting; his tongue was slightly yellow; his temperature 96·8°, and his pulse 74. His bowels moved after breakfast, and he seemed much better. During the day he took about five pints of milk, and some toast, &c., and he slept well at night." Then follows an account of the results of my detailed examination, and an entry of the medicine prescribed for him to be taken three times a day. This medicine he has been taking ever since, until it was finished a few days ago. The official daily record kept by the Manager shows that the patient slept badly the first night, but that he has been sleeping well ever since. I have repeatedly inquired as to his sleeping, and he has told me that he slept well. As to being in gaol, he has had liberty to walk about the estate of some 850 acres with his fellow-patients, and to play billiards, &c.

He was not asked to do any work until he had been in the institution for about half a week; then I myself took him to assist at pulling down some light manuka scrub, which had been burned a few years previously, and, being decayed at the ground-level, was easily snapped off. It is the lightest form of work one could think of, entailing infinitely less exertion than any form of digging, unless a man chooses to set himself to tackle the few larger shrubs, which need the use of an axe. After working at this for about a quarter of an hour a shower threatened. The rest of the party sought shelter in a tent close by, and I took him back to the Home, telling him that it would be well not to do too much at the start. He then spent his morning playing billiards. Since then Mr. ——— has gained strength rapidly, and has each day done a little more work, until now (a fortnight after the date of his admission) he is out working lightly, with frequent spells, on an average about five hours a day when fine. However, the weather has been changeable, and there have been several wet days on which no work could be done. During the present week we started grubbing some gorse on the flat near the Home, and it is apparently to this work that your brother refers so piteously. Curiously enough, when your letter arrived yesterday morning, it was brought across to me to where I was engaged grubbing out some gorse with a mattock, while your brother beside me was keeping a bonfire fed with a pitchfork. The following conversation ensued :—Dr. King: "Well, how did you sleep last night?" Mr. ———: "Oh, like a top. I have slept well ever since the first night." Dr. King: "You 're really looking very well. I suppose you are feeling pretty fit?" Mr. ———: "I never felt better in my life. I 'd go to that pig-hunt on Monday, only I 'm afraid the country is too rough."

[It was arranged early in the week that a fishing-picnic to Karitane was to take place on Saturday. Mr. ——— decided to attend, but said he would not accept my offer that he should spend the Sunday there boating, and then accompany Dr. Alexander and some of the patients on the pig-hunting expedition on Monday and Tuesday.] Dr. King: "How are you getting on at the billiards?" Mr. ———: "Oh, fairly well, but I haven't had many games during the week, because we are engaged on a tournament. I don't know how I shall fare, because I am pitted against a good player; he has to give me —— points, though." Dr. King: "Well, I suppose you don't find life so irksome as you expected?" Mr. ——— : "Oh, no, it 's right enough; but, of course, I would rather be at large." I have repeatedly had similar conversations with Mr. ———, and I say, without any hesitation whatever, that the statements he has made to you are absolutely untrue. He eats well, looks well, sleeps well, and says is he well. It would be a strange and not a very hopeful sign if a man born and bred with the social advantages that Mr. ——— has had, felt no remorse and shame at having reduced himself to the plane in which he now is, but that is a matter which neither I nor any other human being can obliterate.

Neither have we any powers or healing arts such as you assume. There is no drug or substance known which will "cure" a drunkard of his drinking habit, and it is not true, as you have heard, that I have "cured many cases of drunkards" at Orokonui. It will be time enough some three years hence to say how many have permanently recovered of the forty-odd unfortunates who have placed themselves or been placed under our care and treatment; and we shall have succeeded beyond the success of similar institutions in England if 20 per cent. of cases recover permanently.

People are, with excellent reason, afraid of small-pox, from which 75 per cent. of cases recover, and yet they little realise that beside the malady which has come to pass in your brother's case small-pox is a simple and innocent disease. A pockmarked skin is no doubt disfiguring, but compared with the irreparable scarring and blasting by alcohol of the delicate cells upon which all that is noblest and best in humanity depends the ravages of small-pox are trivial and of no account.

I regret to say that the prognosis in your brother's case is unfavourable. I do not think that he will recover.

We will do what we can for him, and I think it would be wiser and fairer if you trusted to us rather than give credence to his complaints.

He did, by the way, speak to me about carpentry and gardening, and I promised him that I would arrange to give him something to do in due course in these directions.

My relationship with him has been most amicable and friendly, and he has never given me any indication that he felt aggrieved or discontented in regard to the institution. Yours, &c.,

F. TRUBY KING,
Medical Superintendent.

——— , Esq., Erehwon.

When examined next day by Dr. Alexander and myself, the patient confirmed everything stated in my letter as to health, sleep, the taking of medicine, &c. When confronted with what he was alleged to have written, he was much disconcerted, and said repeatedly, "It is all a mistake. I came here under the impression that I was to be treated by injections and cured in a few weeks." He continued, "We were assured that you had cured several persons in that way. The medical treatment you have given me is not what I understood by 'treatment.' I would not have come had I known that I was not to have injections." Further, he volunteered that he had received every attention and kindness, and said that his brother had not been warranted in writing as he had done, that his letters had been misinterpreted and distorted; and, finally, that he insisted on my seeing them "because you have treated me like a gentleman, and I should not like you to think so badly of me." However, when asked by Dr. Alexander to sign a telegram the next day asking for the letters to be returned he became indignant, swore, asked what right Dr. King had to see his private correspondence, and refused absolutely to satisfy my "curiosity."

Certain defamatory newspaper articles, written by two ex-patients, call for passing notice. The statements contained in the articles reflected especially on the Manager, but as I have already conclusively shown you they were as baseless as the charges referred to in the foregoing letter. I should have liked to publish a short refutation in detail in this report, but defer to the opinion of the authorities that this is quite unnecessary on account of the obvious rancour and the limited moral responsibility of the authors. However, I give in Appendix A extracts from two letters written by these malcontents before the management incurred their hostility. The principal complaint made referred to the fact of some patients from Seacliff Asylum being employed on the estate, and a few employees being drawn from Sunnyside and Seacliff. As to the desirability or otherwise of selecting some employees from tried members of our asylum staffs, and of utilising asylum labour in pioneering work in such a case, I have no doubt whatever. The asylum patient whom one can select for such work is not only harmless and unobtrusive, but is on the whole a much more capable worker than the average alcoholic. The small party of some fifteen Seacliff patients have done willingly and with zest more to improve the estate in eighteen months than could be effected by the whole of the inebriate population at Orokonui in ten years. Their withdrawal means that more paid labour will have to be employed in future at the public expense if any active progress at all is to be made in the way of developing the estate and its resources.

I have clearly shown you that the inebriate patients themselves nearly all recognised the advantage of having the Seacliff party at Orokonui, and were very friendly to them. Even when one or two of their number worked the "insane element" as a platform, they failed to evoke any general enthusiasm for their grievance in the Home itself.

The quarters of the Seacliff patients were quite sufficiently remote from the Home building, and no intercommunication or mixing was in the slightest degree necessary. However, we decided that it was expedient to remove all ground for anxiety by transferring the Seacliff patients back to the Asylum when we found that a few malcontents were succeeding in causing alarm among their friends and relations. Nothing is easier than to make a successful appeal to popular misconceptions about asylums and the insane.

For my own part, I cannot say how strongly I feel the injustice and cruelty of the opprobrium which even well-meaning people are inclined to attach to the idea of insanity. If, of his own volition, a person has brought himself to almost any conceivable pitch of degradation through the vice of drinking, it may be felt by the public that his course of life has been reprehensible, but it is, at least, respectable, and he should be the subject of our most tender concern and solicitude. If, on the contrary, through fever or any other bodily sickness, or through the stress of motherhood, poverty, or grief, the reasoning faculties should have become clouded, it is permissible to regard our less fortunate fellow-being as a pariah; and it is not even bad form for a demoralised inebriate to scornfully apply the epithet "lunatic," and beg protection from possible contamination. The great majority of the insane are not the pitiable creatures they are supposed to be; they still have most of the qualities we any of us possess more or less intact, and by their very disabilities they appeal to any human being who is capable of feeling at all. Nor are the people who enter the asylum service as a rule rendered hard and callous by their calling. There are black sheep everywhere in the world, but, as a class, I have no hesitation in saying that I know no more considerate or humane men and women than those who attend on the insane. There can be no greater misconception than the assumption, recently given utterance to in public, that employees are selected simply on account of physical strength. Nothing can be further from the truth.

It was fortunate for the patients sent to Orokonui that I could select attendants from tried members of our staff at Seacliff, and I can say with some pride that, in spite of many trials of patience and temper, not one of our men has discredited himself throughout the whole period during which the Home has been opened, and we have managed to avoid resorting to any of the punishments which the law entitled us to enforce with regard to the inmates.

The difficulty of inducing the male patients to work would have been insuperable if I had not been more than loyally helped and supported throughout by Dr. Allen, whose devotion and zeal in this, as in the rest of his work, have been beyond all praise. I have, indeed, been singularly fortunate in having associated with me two colleagues of the capability and untiring energy of Dr. Allen and Dr. Alexander. For the last two months the main work at the Home has devolved on Dr. Alexander, and I wish that, for the sake of the institution, he could have been

induced to accept the position of permanent Superintendent, for which he is so eminently qualified. I appreciate the desire of the authorities that I should continue in charge of the institution myself, but the primary pioneering work is finished now, and I think it necessary to devote my attention more exclusively to Seacliff.

When I say that the primary pioneering work is finished, I do not mean that there is not much still to be done at Orokonui. There is everything to be done; and that, in my opinion, is what constitutes its special fitness for making men of the patients who go there. At the present time every patient is doing work of some kind—we have achieved so much—but more variety and a wider scope is desirable. If the sympathies of the men can be enlisted in unselfishly developing the latent resources of the estate, and in making it a better place for those who come after them, they will be doing more towards their own regeneration than anything which can be prescribed from the Pharmacopœia.

It must not be supposed that the unfortunate types of alcoholic degeneracy to which I have been forced to draw attention in the text of this report and in the appendix are a fair index to the whole population. We have had a few individuals at the Home who have shown themselves unselfish, capable, and energetic, and it is a pity that such men cannot act more effectively as a general leaven to their weaker brethren.

All that I have said points, I think, to the necessity for exercising reasonable care in selecting the patients who should be sent for treatment, and to the necessity for providing means of classification. With regard to male patients, this can be carried out to a great extent by placing one class of patients in the new building, now vacant, which was erected on the opposite side of the valley.

I have been guarded as to the prognosis of the patients discharged and under treatment, because in the face of English experience one has no right to be unduly optimistic; but we see no reason to doubt that a fair number of the patients will recover. So far about half of those discharged are known to have relapsed, but we know that most of the others are still keeping sober. With a large estate like that at Orokonui we should be able to insure a larger proportion of recoveries than in the more limited English institutions, provided that the committal basis is reasonable and the friends and relations learn to act fairly and sensibly in the way of backing up the authorities in their efforts to save the patients from themselves. I say "learn," because the natural tendency is all the other way, and we find that a very little whining and importunity upon the part of an inebriate suffices as a rule to upset the earlier sound judgment which led the friends to call in the aid of law and authority, and converts them into suppliants for the patient's immediate release. Few of us like living under restrictions and apart from our ordinary associations for any long period of time, even in such comparatively favourable circumstances as one finds on board ship. When thrown together by chance, without accustomed duties and outlets for emotion and passion, men especially can never be kept from feeling their position and railing at their lot; and if they have been for many years uncontrolled self-indulgent drunkards the situation at times is apt to become trying in the extreme. There are not the natural conditions present in any Home for inebriates which go to form a happy and contented community. In the typical drunkard the higher social qualities are more or less in abeyance—there is no give-and-take in him; he is irritable, selfish, self-willed, and *blasé*; initiative is frequently almost extinguished; and the control and discipline which he has failed to exercise from within is doubly repugnant to him if imposed from without. But worst of all is the lack of moral sense—a special failing of the inebriate, and the greatest of all obstacles in the way of reform, especially where a number have to be dealt with in one institution. Indeed, this point makes me doubtful whether institutions for inebriates will ever succeed in reclaiming more than a comparatively small proportion of patients. As Dr. Clouston says, "The moral atmosphere tends to be low, the patients keep each other in countenance, you cannot restore the sense of shame and of self-respect, and they plot, and fan each other's discontent." These tendencies are certainly very marked, and it could scarcely be otherwise. However much influence for good an earnest, strong, sane man may be able to exercise over an individual drunkard—and we know that such an one can and often does exercise a most potent reforming influence—his power is too often negatived in a Home by the tendency of patients to submit everything to their own tribunal, which, regarded compositely, cannot be expected to take high ground, and in practice is found to regard alcoholism and its results as a very venial matter. As Dr. Wilson says, "One of the most obvious features of drunkenness is self-excuse"; and this is very much fostered nowadays by the fact that the public is inclined to apply to all cases and to carry to an extreme the idea that alcoholism is simply a disease, and not at all a vice. I have found great difficulty in persuading patients, even individually, that they have any responsibility in the matter, and to convince them as a community is a much harder task. They try to lay the whole blame on *heredity* and *environment*, and their friends too often support them in this.

It would be much more satisfactory if the public could be brought to an adequate realisation of what may be reasonably expected from detaining and treating inebriates in special institutions. Friends would then be in a position to fairly decide on the question whether a particular patient should be sent to a Home or not; and, *having once decided, they might be expected not to change their minds merely because of the patient's inevitable self-pity and importunity.* If the relations could only steel themselves to be a little firmer and more resistive, it would be better for themselves and far better for the patient. Writing on the "Mismanagement of Drunkards," Dr. George Wilson says, "We find it an almost invariable rule that, because of his gift for making things unpleasant, he" [the drunkard] "is allowed to have even more of his own way than are those who behave properly. It seems to me quite the most immoral effect of drunkenness that it leads to the complete demoralisation of the home. Be the drunkard father, or son, or brother, all the domestic arrangements are suited to his perverted tastes. People wait up for him far into the morning hours, meals are kept late, every one else is put to discomfort in order to please him. Worse than that, the whole household must learn to shield him, to deceive, to pretend, to lie,

rather than admit the facts of the case. This is a mistake, for which, of course, the friends are most to blame. It is natural to them, especially to the more tender and sympathetic sex, to sacrifice both their comfort and their consciences to the erring member. But we doctors must inculcate a better way. When I am asked to treat a drunkard at home, one of the first things I insist on is that there shall be an end to all pampering of the patient. He must be plainly told that he has clearly demonstrated his unfitness to direct his own life, much more his incapacity for the headship of a household. He is by habit overexacting; he must be prevented spoiling other lives. He is already too self-indulgent; he must be compelled to accept unpleasant things. He is irregular and unpunctual; he must take things when they are due or go without them. He is unkind, inconsiderate, cruel, and sometimes brutal and violent; he should be ignored until he learns to give as well as take. . . . . In short, the mother or father, the wife or sister, the brother (who, by the way, less often needs the instruction) must be instructed how not to deal with a prodigal in the time of his prodigality. For the fatted calf, which suits the repentant home-comer, is most unwholesome food for the incorrigible and impenitent. This question of shielding the drunkard, and practising deceit and lying on his behalf, is a difficult and important one. An obvious disability of the drunkard is his *want of a sense of sin*, and a great dishonesty about his vice." Dr. Wilson contends that it is a great mistake to minimise the gravity of his condition to the drunkard himself. "All the evil and danger of his vice should be brought forcibly home, not in a petty way, but in a manner which will be impressive and permanently convincing. . . . . The difficulties of managing a drunkard at home follow him to any institution where he is sent for cure. Not only do the disabilities of the patient prevent successful treatment, but the mistaken kindness of relatives is also in the way. People are anxious that the poor man should have plenty of amusement, whereas one wishes him to learn how not to be amused. He is of idle habit, but he and his people seem to think work unnecessary, if not an injustice. For years the man has been a slave to his palate and to his appetites, but his friends are still very anxious that he should be richly fed. He has made a long practice of the art of lazy comfort, but still it is expected of us that we should provide a lap of luxury for him such as might be fitting for a worn-out and conscientious martyr to good works. To be appropriate, it seems to me that institutions for drunkards should teach habits of regularity, hard work, and forgetfulness of bodily states, except in so far as is necessary to health. Similarly, his mental state should be treated so as in every way to induce him to see the nature of his vice, to realise his weakness of will, to sink his own selfish desires, to rid him of self-importance, self-pity."

The question of the influence of religion is a very delicate matter. Obviously great efforts have already been made in a large proportion of cases before the patient reaches a special institution. At the same time, I fully recognise how many reformed drunkards owe their regeneration to the clergy. On this point Dr. Wilson says, "We are all familiar with cases of complete and permanent reformation following a religious experience of an impressive kind. As was said on the eloquent speech by the clerical guest at the dinner of the Association, ministers are learning that there are states of mind, even in those who are still sane, which the physician can most effectually deal with; and there are cases, even within the walls of our asylums and retreats, who most require the help and guidance of a pastor. But the clergy are not without blame in this matter of too lax a view of drunkenness. They also have learned the lesson which our too easy doctrines have taught. And if we are to call in the minister to help the drunkard, we must see to it that he is one who will not be afraid to speak the truth as his religion teaches it without any importation of mildness from medical and scientific doctrine. . . . In so far as modern teaching repudiates moral responsibility because of 'flaws in the flesh' or 'taints in the blood,' it is an instruction which is only harmful to the victim of vicious habits."

Much that I have felt obliged to say may well seem the reverse of reassuring to the friends of patients placed in Homes for inebriates, and may further incline some rather to aid than to resist applications for discharge, but I cannot say that I think this reasonable. In the vast majority of cases—practically speaking, in every case—the friends have tried everything and are at the end of their resources before they take the extreme step of having a drunkard committed to a Home for inebriates. We find that the patients sent to Orokonui have on the average been drinking excessively for from twelve to fifteen years, and very few for less than ten years. The gravity of the situation can scarcely be overstated. It is felt that some final effort must be made to save the patient if possible, and the question is whether anything else can be recommended that will give such prospects of recovery as a Home for inebriates can offer. In the great majority of cases I am satisfied that there is no other means of treatment available which would give even the small proportion of good results I have indicated; though, if the patient had means, I should not hesitate to advise that every effort should be made to get him treated apart from an institution. I have no doubt that Dr. Clouston is right when he says, "In real life the best thing we can do is to send our cases to distant farms, or manses, or doctors' homes under a firm moral guardian"; but the difficulty always is to get the suitable guardian, and to get the patient to consent, though with our present law in force more than mere moral suasion might be used with effect.

The question of the length of time for which an inebriate should be compulsorily detained in an institution is one of extreme importance, but it is not one which admits of a definite and finite answer. As I have already shown, the tendency in the Old World has been to ask for longer and longer periods of detention. With perennial hopefulness the authorities have prophesied that, given more time, the results would be less disheartening. They may be right—indeed, statistics so far as they go tend to show that more could really be achieved if inebriates were forcibly kept from drink for longer periods—but it must not be forgotten that the whole matter is in an experimental stage, and that up to the present time none of the three-year sentences under the Inebriates' Reformatories Act have expired. My own impression is that too much is expected in the way of reform as the result of these long periods of detention. I say this with all diffidence, in view of the general consensus of opinion in the opposite direction. However, this is not a matter which can

be finally settled until there has been an extended experience as to the actual results of long sentences. Dr. George Wilson says, " Whether a retreat or an asylum can be conducted so as to provide sufficient discipline, and at the same time to give the necessary opportunity for initiative, is, I think, an open question. The task is certainly very difficult. And that leads me to express my deliberate conviction that most cases of drunkenness are not benefited by a prolonged residence in an institution where the patient lives a life which cannot be described as free or independent. The atmosphere of an institution is not one best calculated to restore the positive side of character." On the other hand, no one recognises more clearly than Dr. Wilson does that a reasonable period of time must be allowed to admit of sufficient organic improvement in the brain and system generally to give the patient a fair chance of being able to face the outside world without an inevitable relapse. Speaking generally of the loss of purposive function in alcoholism, and particularly of the loss of initiative, he says, " Initiative is a process which transcends experience. In initiative activities the nerve-movement does not simply follow the paths which have already been formed, but reaches forward to form new patterns of nerve-connections. . . . . The process is, in some sense, a diffusion of nerve-movement beyond the organized paths and patterns of brain cells and fibres—that is, a kind of process which is implied in all mental activities which denote development. The act of understanding; the development of an idea or a conception; the process of generalisation, as well as that of analytic refinements; the most humble flight of imagination; the extension of sentiment, ambition, new projects, hope, assurance: all depend upon some onward and formative activity, such as has been hinted at. And we shall certainly see, if we look for it, that there is in drunkenness a great loss of this kind of activity manifest in every faculty which the drunkard has left to him. . . . . Also, it is probably the beginning of recovery of this kind of activity, after a few months' abstinence, which carries the drunkard past a safer judgment, and which fills him with the illusive hopefulness and the false estimate of his strength, to which the name of 'spes vinosa' has been given. That is a critical period in the convalescence of the drunkard, and one which physicians have not sufficiently recognised—a stage exactly comparable to the misleading feeling of strength in a patient who is recovering from any acute bodily illness, when, if he is not prevented, he will undo his recovery by rashly exposing himself to danger."

In confirmation of this, I may quote the report of actual experience at Hancox's Home Retreat (C.E.T.S. Reports, 1901): " The chief difficulty the Superintendent has is to persuade those patients who do not enter the Home under the 1879 Act to remain the time that is necessary for their recovery. They seem to think when their physical health is improved, and they themselves feel invigorated and strengthened by the regular life and habits, the discipline of the Home, and the healthy work and recreation so much in the open air, that their will-power is restored, and that in the future they will easily be able to resist the temptations which will meet them when they go out into the world again." They not only *feel* safe themselves, but, as I have said, they easily persuade their friends that they *are* safe. The warnings of past experience are negatived by the fact that a few months' sojourn in a well-regulated Home brings the average inebriate to a condition of bodily and mental fitness which quite transcends any improvement within the previous experience of the friends; and by contrast with the obviously degraded mortal, whom they have for long years despaired of, this new man seen at his best may well seem almost divine in his redemption.

What are we warranted in saying as to the period for which patients should be committed to the Orokonui Home? I have no hesitation in asserting that under no circumstance whatever should any person be sent for less than six months, and in the vast majority of cases at least twelve months should be insisted on. Possibly the power of the Magistrate might with advantage be extended to commit for longer periods than this, but I am of opinion that if there is no reasonable prospect of recovery in twelve months the case should not be sent to a hospital Home at all. Such a patient must be regarded as virtually incurable, and if he is to be provided for at all by the State, it should be in some institution more like an English reformatory. The only recommendation which I have seen in favour of allowing short periods of detention is contained in a tentative suggestion made in Dr. Branthwaite's current report. He says, " I am quite in accord with those who insist, as a first principle, upon the value of long-continued enforced abstinence; and I am inclined to agree with the licensees of some retreats who, as a matter of principle, decline to accept any patient for treatment who will not consent to a term of detention extending to twelve months or over. There is no doubt whatever that the longer-residence cases do better than those of shorter terms. It is, however, undesirable that every institution shall make a hard and fast line not to admit short-term cases. There are many inebriates, especially men, who are tied to their occupations and cannot afford to retire into seclusion for long periods. It is such persons, finding themselves blocked from treatment in a recognised institution by the necessity of signing for impossible months, who are driven to resort to cures which promise recovery in three or four weeks. I cannot help thinking that some good results might be obtained amongst persons who could manage to undergo control and treatment for short periods only. I am not prepared to advocate the admixture in one retreat of short- with long-term cases, but I do think that, especially near London, there is a great demand for an institution entirely devoted to the reception of patients able and willing to sign for a month, or even less. Such an establishment should more closely approximate to a hospital than to an ordinary retreat of the Home type, and should be designed for, and be prepared to receive at the shortest notice, the most acute type of cases. Although the percentage of permanent good results would necessarily prove smaller than the long-period Homes produce, still, a retreat such as I suggest would at least afford a chance of recovery to many who are at present debarred by commercial and other ties from the benefits of longer control. It is possible also that many patients, having tried the shorter periods and experienced failure, would, when circumstances permit, willingly consent to more extended treatment."

This, I submit, is a most valuable suggestion, and, if anything further is contemplated in the direction of providing hospitals for the treatment of inebriety, it would be wise to give a fair trial to a small inexpensive institution for the purpose indicated near some large centre of population. Short-period cases sent to an ordinary Home are a disturbing element, and cause much discontent and jealousy. I have known alcoholic patients recover and remain permanent abstainers after a few months' stay in an asylum, and the trial would, in my opinion, be well worth making, because it would tend to reduce the number of needlessly long detentions, and it would enable a larger number of patients to be treated annually at a moderate cost.

The question of expense is, indeed, a very important one in the matter of the treatment of inebriates by the State. Assuming that in our long-period Homes we could average 20 per cent. of recoveries over all classes committed—voluntary and involuntary, men and women—and assuming that maintenance could be reduced to a cost of £2 10s. per week, the expense to the State of each patient restored would be nearly £400 for twelve months' treatment. The average fee payable so far has been just £1 per week each for the forty-eight committals, and in framing my estimate I have taken this into account. In reality, I doubt whether the present comparatively small number of patients under treatment at Orokonui could be suitably kept for £2 10s. per week, if full allowance were made for interest on primary capital expenditure. The staff must always be a large and expensive one, and the carrying-out of a scheme of classification would not effect much saving, because more attendants would be needed. Up to the present time we have been unable to give much special advantage, beyond choice of the best rooms, to the patients who have contributed towards their maintenance; but they have had little cause for complaint, because we have levelled upwards and treated all on a liberal scale. Practically no comment or objection has reached me in regard to the lack of classification, except on the part of two of the non-paying patients!

I have scarcely touched upon the question of the retreat for women. For reasons which I have already stated to the authorities, I am satisfied that, as soon as possible, this should be entirely separated from the neighbourhood of a Home for men. English opinion upon this point is very definite. The treatment of inebriety in women is for the most part extremely unsatisfactory, and the few female patients who have been sent to Orokonui show sufficiently clearly that in the meantime at least there is no widespread tendency in this colony to have women committed to institutions. The retreat at Orokonui is in every respect a charming residence, and I can only regret that Miss Thomson's devotion to her charges cannot in the nature of things meet with the one reward which would alone satisfy her.

Religious services were conducted at the institution for a long time by a very able minister of religion, and since he left us patients have attended services at Waitati. I have been trying to arrange for regular services in the Home, but this is a matter of some difficulty, on account of there being so many denominations among the inmates.

The main industries which should be pushed on are—(1.) The fencing of the estate. (2.) Draining of swampy areas. (3.) Ordinary farming operations on the cleared ground. (4.) The reclamation of some 70 or 80 acres of tidal flat. (5.) The completion of the works in connection with water-supply. (6.) The provision of Pelton wheels to supply electric light and power for the making of bricks and tile drainpipes at a cheap rate. The clay has been tested for both purposes, and is found to be eminently suitable. (7.) The development of poultry-farming as a specialty. (8.) The planting of forest trees on any hill-slopes which happen to be unsuited for agricultural or pastoral purposes. The hills are peculiarly well adapted for the growth of red-gum, stringybark, and other eucalypti, of which there are already some flourishing patches.

The last words which my colleagues and I feel impelled to say, as the outcome of the work which we have had in hand, concerns the question of *prevention*. Can we say or do anything that will serve to lessen the frequency of the disease which we have been called on to treat, and which we can only regard as virtually incurable when once established? I have spoken of "recovery," but in reality perfect recovery does not come within the range of our experience, and is not to be expected.* If, in the scheme of creation, it has been ordained—as we believe it has, and as all experience teaches us—that throughout the life of man on this earth there shall be an intimate association and relationship between body and mind, we cannot conceive that the infinitely delicate and marvellous tracery of the brain can be structurally changed and debased without lowering at the same time the potentialities of the mind and the moral nature. It will be objected by some humane and tender-hearted people that it is cruel to tell the chronic alcoholic that the past is irreparable and that, however much he may try to aid us, we cannot give him back an intact and perfect brain. The *truth* often *seems* cruel; but for the moment we are considering not the man who has erred, but the thousands who are tending to err if they are not forewarned of their danger. Moreover, there is no real kindness in buoying up the alcoholic with a false estimate of his strength and powers, or in concealing from him the fact that he has already entered on the broad path which leads to destruction, and that he can only be saved by a supreme personal effort. In saying this we are saying something much milder than what is implied in the teachings of the parable of the talents which surely has some remote application here. We want to save the man from himself; or, rather, we want him to realise his danger before it is too late, in order that he may exercise the powers he still has and save himself. It is not we but the Creator who has made the past irre-

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*(*a*.) Dr. Clouston says, "I am safe in saying that no man indulges for ten years continuously in more alcohol than is good for him, even though he was never drunk all that time, without being psychologically changed for the worse."

(*b*.) "Alcoholism is a disease which on an average may be said to have taken from three to five years to develop. All these years the tender structures of the cortex of the brain have been deteriorating in one realm after another."—"Vice and Insanity," by Dr. George Wilson.

(*c*.) The average period during which the patients committed to the Home at Orokonui have been addicted to excessive drinking exceeds twelve years.

parable for the alcoholic, to the extent to which it is irreparable, and I fail to see how human beings can logically expect a special intervention and departure from the laws of nature in favour of the man who brings upon himself the disability of alcoholic degeneration, and yet accept with comparative resignation the bodily and mental limitations imposed upon the victims of pure accident and misfortune.*

How far the drinking habit is to be regarded as a misfortune and how far as a vice is a matter so inextricably bound up with the ultimate question of human responsibility and free will that it cannot profitably be discussed here. It is of vital importance, however, that the plea of hereditary tendency should not continue to be generally advanced by the public as an excuse for failing to exercise the will-power in regard to drinking. The cases in which alcoholism is comparable to kleptomania or any other form of impulsive insanity are so comparatively rare as not to affect the main question. One might as well advance the existence of kleptomania as evidence that no one is responsible for theft; or of pyromania that no one is responsible for arson. Even where a marked hereditary predisposition exists in regard to insanity itself, the individual can, in a large proportion of cases, ward off actual mental disease by a wise regulation of his life. There is, as Dr. Clouston says, no reason why "potentialities should be allowed to become actualities." I quote the following from Dr. George Wilson's emphatic protest against the "Plea of Heredity": "One excuse we have given the drunkard by our too indiscriminate belief in the importance of heredity. . . . . Granting for the sake of argument that a tendency to drunkenness is inborn in the offspring of drunkards much more than in the children of the sober, what has society gained by the information? The drunkard has learned his part of the lesson aptly; he has readily grasped the fact, and makes use of it, that this teaching gives him an excuse for his vice. From the time that he learns that some one of his forebears was a drunkard he begins to regard himself as a victim of an unfortunate law of nature—an object of pity rather than, as he ought to be, an object of scorn. Also our teaching has done considerable harm in its suggestion to the sons and daughters of drunkards. I speak from observation, and not at random. Several cases occur to me which prove that young people who have a drunken family history are, to their hurt, taught to expect that they will likewise become drunken. . . . . Our teaching should be all the other way. *A bad family history is a good excuse for total abstinence; it is no excuse at all for promiscuous drinking.* It would be quite as sensible if a man who slept in a ditch explained his illness by a reference to a rheumatic or a phthisical family history. A person who has any such idiosyncrasy should be guided and corrected with greater severity, and not with less than the normal individual. Let us impress on such an one as strongly as we can how important this matter is for him. Let us warn him that there is no excuse for him, but let us not be so misguided as to tell him that he is likely to become what his father became, because there is something in his nature which makes for drinking."

But in the majority of cases nothing special can be reasonably advanced as to heredity, and we must look for the causes of inebriety elsewhere. The most fundamental reason for drinking, apart from the question of custom and company, is, of course, the feeling of elation and pleasurable well-being which ensues, and the sense of detachment from the ordinary cares and responsibilities of life. The drunkard on the whole falls back into a more primitive and a lower phase of existence, in which he is less trammelled by the restrictions of civilisation and conscience. The attaining of this result we may assume will always have its attractions. Alcoholic drinks, *per se*, offer practically very little temptation; many of them are, indeed, repellant to the natural sense of taste, and only the man who seeks for a drug to kill the "crave" is shallow enough to suppose that by making a man dislike whisky he could be prevented from intoxicating himself by other means such as methylated spirit if nothing else were procurable.

Among the causes apt to pave the way to excessive drinking which I believe we are most called upon to counteract are tradition and ignorance. It has been handed down to us, especially through literature, that to be able to take an excessive amount of alcohol without becoming insensible is an evidence of strength and manliness. The glamour of romance still clings to the feat of drinking one's fellows under the table, though Seneca said nearly two thousand years ago, "Is it not a magnificent virtue to swallow more wine than the rest and yet at last to be outdone by a hogshead?" Sir Dyce Duckworth, writing on "The Relation of Alcohol to Public Health," says, "It is to be hoped and expected that with the spread of knowledge and education alcoholic intemperance may come to be regarded always and everywhere as vicious and reprehensible. It is a grievous matter that it should be regarded in any quarter as a venial offence." That it still is so regarded, that there still is no conception in the public mind of the irreparable degeneration of the brain brought about by alcohol, is frequently borne in upon me by the way in which reclaimed drunkards are offered drink by their acquaintances. The knowledge that a man has been for months in an asylum on account of inebriety does not safeguard him from being offered liquor,

* It must be understood that I am trying to convey to the authorities the gravity of alcoholism regarded as a disease, and that I am not addressing alcoholic patients. No patient at Orokonui has been told by us that he has already done irreparable injury to his brain, though that fact might be inferred from our having to impress on every inmate that any further drinking would certainly bring about permanent structural changes. However, it is imperatively necessary that the public should know the facts, and there is no special objection to letting the inebriate himself know that long-continued abuse of alcohol entails organic degeneration and certain permanent disabilities. There is no harm in his even coming to realise that some such change is already in progress in his own case, and that he has lowered his mental and moral stature, reduced his range of potential development, and in that sense done himself irreparable injury. He has every reason to be thankful that the way to reform is still open to him, and that though he cannot expect to attain the highest and widest development of which he was originally capable, he may even yet do excellent work in the world. In one direction, indeed, the fact of having been an inebriate is recognised as giving a man a special power for good—viz., in the direction of inducing temperance in others. The fact that reformers of this origin usually take a somewhat narrow view of the situation, and tend to be fanatical and filled with the one subject, is no doubt an expression of the limitation of range imposed by organic brain-changes; but this does not prevent their exercising a very potent influence over their fellows.

immediately he is released, by men who count themselves his friends, and we have had the same experience in connection with the Home for Inebriates. If the persons guilty of such crimes were ordinary criminals, their offence would not be so unthinkable; but what amazes one is to find that they are often simply easy-going, good-natured people who do not realise that they are doing anything specially wrong. The men who offer to bet £5 that they will make their comrade, who has conquered his vice, drink again are not necessarily cruel people in the ordinary acceptation, indeed they are usually the reverse. Their fault is thoughtlessness and the densest ignorance.

In the way of prevention we cannot hope to cope successfully with inebriety as a disease until it is thoroughly realised by the public how grave and incurable the malady is when once established; and until it is further generally recognised and admitted that the man who takes drink to excess commits a disgraceful act, while the man who tempts another—especially a drunkard—to exceed, is a criminal.

I have, &c.,
F. Truby King,
Medical Superintendent.

APPENDIX A.

1. Copy of letter from an ex-patient at Orokonui Home to an acquaintance. This letter was returned to the Superintendent by the lady to whom it was written:—

My Dear Miss ———,— The Inebriate Home, Waitati, 12th June, 1902

In the first place, let me state that what I was afraid would prove a penitentiary or prison, with perhaps one or two of the worst penal features chamfered off, in actuality turns out to be a "home" in nearly every acceptation of the term.

Our table is excellently supplied, the sleeping accommodation quite equal to that of the best hotels, while the scenic or landscape views on all sides of the Home are simply charming. In a word, I feel myself more at rest and settled in mind and body than I ever hoped to be again.

* * * * * * * * *

I trust most devoutly that this will find you happy, and well in health. My own is excellent, thanks to kindly nursing, salubrious air, a good table, and regular hours and habits. We have plenty of outdoor work and exercise; a little boating and fishing; a capital billiard-room and table; a first-class piano, and occasional singing; and, in fine, everything conducive to health and contentment. Kindly remember me to A., and Messrs. B. and C., and believe me to remain,

Yours, &c.,

———.

2. Copy of paragraph printed in a Christchurch newspaper at the New Year, 1903. This paragraph was extracted by a journalist from a private letter which he received from an inmate of the Home, and was not intended by the writer for publication. It was written at the end of a five-months sojourn in the Home:—

"There is a mixed crew here—a parson, a J.P., a doctor, a Customhouse officer (pensioner), and others. The place is everything that the most difficult to please should approve, and better calculated to keep a fellow from drink or to cure him than all or any means ever I heard of before."

The special interest attaching to the two foregoing extracts is the fact that they were written by the very persons who subsequently published defamatory articles concerning the Orokonui Home.

APPENDIX B.

Proposed Amendment to the Inebriates Act of 1898.

1. I consider the existing Inebriates Act specially needs amending in the direction of providing for patients leaving the Home on probation. This was possible under section 48 of "The Lunatics Act, 1882," referring to habitual drunkards, but is not allowed in any way in the special Inebriates Act of 1898, under which the Orokonui Home was established. The only means available for getting away from the Home (except for a few days as provided for in the authorised rules and regulations) is by an absolute rescission of the committal order by a Magistrate, and then the authorities cease to have any hold whatever over the patient. Such a position is unfortunate, because a considerable number of cases arise in which it is desirable, in the interests of the patient and his family, that he should return home before the completion of the term originally stipulated, and yet where it is extremely important that he should not feel himself free to resume drinking habits with impunity. In such cases, before lending any countenance to the rescission of the order, I have been in the habit of obtaining from the patient and his friends a form of undertaking engaging to apply for recommittal to the Home for twelve months should there be any relapse prior to the date

of expiry of the original order. The taking of any alcoholic liquor whatever is regarded as a relapse, and the patient signs a request for the relations to take action in his own interests should he fail to apply for recommittal himself. These undertakings have proved very effective, the patient tending to keep sober at least until the date of expiry of the original order. As I have already indicated, patients and friends tend to become very importunate on the matter of early release, and it seems to me highly desirable that the law should provide that, in every case where a patient has an order rescinded or is allowed home on probation, in the event of relapse he should be returned to the Home for at least twelve months.

The English Act provides that a license to be at liberty may be issued after three months as soon as a patient gives evidence of sufficient recovery to make it appear reasonably possible that he would be able to keep from liquor and take care of himself. This license permits resumption of ordinary duties of life. The permit remains in force as for remainder of sentence, or so long as patient refrains from intoxicating liquor. Should he drink, the license is revoked, and the patient is compelled to return to the Home. Some person is required to become responsible for the licensee whilst at liberty under license, and to render monthly reports to the Superintendent as to his behaviour. If required, the police can be asked to report.

In our Act of 1898 the matter of rescission of order is left entirely to the Magistrate, and a report from the Superintendent is not required, though it has always been asked for in practice. Detention for alcoholism is evidently regarded as a question of expediency, not of necessity as in the case of insanity, and it is obvious that family and pecuniary affairs have much more to do with the desirability of release in the case of inebriates than in the case of the insane. Nearly half of the patients who have left the Home at Orokonui have had their periods of detention curtailed by Magistrates for various reasons. In several of these cases the patients should never have been committed; in most cases there were more or less urgent family reasons for the patient's return home; and in some cases it was obvious that the patient's friends had asked for long periods of detention under the erroneous impression that rescission could be obtained at any time on applying for it.

2. Power should, I submit, be given to the Superintendent to discharge any patient from the Home if, in his opinion, the case is from any cause unsuitable for treatment.

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