to instruct the payment from his estate of whatever sums the Sheriff may deem equitable for the support of those dependent on him.

The application to the Sheriff may be made by relatives or friends, or by the Procurator Fiscal; this last is a most important provision, for many inebriates after liberation might revenge themselves on those who sought their seclusion.

The retreat to which habitual inebriates of the lower social grades would be committed would be one of the Labour Settlements—practically Industrial Reformatories—which the Committee desire to establish at various places throughout the country, in which residence, abstinence, and occupation would be alike compulsory, but where reformation, not mere confinement, would be the constant aim.

These Settlements are to receive vagrants, beggars, habitual petty offenders, and habitual inebriates. The mixture sounds very hopeless, but legislation cannot sift the social dregs too finely; what is salvable can only be got out by the patient personal efforts of those who have charge of them, and these efforts would be quite useless without such compulsory powers.

Public opinion in Scotland is fully ripe for the legislation proposed, and most earnestly desires it.

The Uses and Limitations of Mechanical Restraint as a means of Treatment of the Insane. By P. Maury Deas, M.B. Lond., Wonford House, Exeter.

I do not wish to enter into any dissertation on the question of mechanical restraint, as such, or to conduct the discussion into an academic debate on the ethics of mechanical restraint. I want to take a more limited view. I want this discussion really to be, if possible, an interchange of views as to the best way of treating and managing certain difficult and exceptional cases which crop up every now and then. I propose to give you the benefit of my experience in dealing with some exceptionally difficult cases, in which I have found a modified use of mechanical restraint beneficial to the patient.

Now, in regard to this subject I make one or two preliminary remarks. I have had the advantage of having had experience both in a large county asylum for fifteen years, and also now for a considerable time in a hospital for the

insane for a different class of patients—patients of the so-called higher and educated classes; and I think that there is a considerable difference as regards the occurrence of these difficult and intractable cases. I am bound to say that, as Superintendent of the Cheshire County Asylum, the number of cases in which I felt at all inclined to use mechanical restraint was extremely small. In fact, there was but one, and that was exceptional, which rather tends to prove my statement, as it was the case of a private patient, of quite a different class to the rest. It was the only case to which I can look back and say that I would like to have used mechanical restraint, and your present secretary, Dr. Macdonald, whom I had then the pleasure of having with me as medical officer, will be able to bear me out that I was then as strong an opponent of mechanical restraint as could be found anywhere. Brought up in a school which looked upon mechanical restraint as an opprobrium, and a thing that should never be entertained, except under pressure of very extreme circumstances, I am bound to say that my experience here during the last eleven years has led me to modify that view, and my opinion now is that there is certainly a class of cases received here in which the use of mechanical restraint is beneficial.

Now I want in the first instance to point out some limitations as to the use of mechanical restraint. First of all, limitation as to cases. I think that it should never be used except for the protection of the patient; and not for cases of violence or destructiveness. These can be dealt with in other ways. I still adhere to the opinion that I have always held on that point.

Then, secondly, as to the limitation of means. My observations are concerned with the means for limiting the movements of the arms and hands. I have nothing to say on the question of general restraint, or modes by which the whole body is restrained, and express no opinion about them. I have had no experience of them, but it seems to me that they are attended by too much risk and by too many disadvantages to allow of their being used as a method of general treatment.

After these preliminary remarks I shall try to indicate shortly the kind of cases in which I think mechanical restraint may be used. There are, first of all, surgical cases. They do not offer opportunity for discussion. Then, with regard to suicidal patients. Ordinary cases can, of

course, be quite well treated by ordinary means; but my experience here has been that there are exceptional cases of this class—cases complicated with violence, and of a marked suicidal tendency, involving a great deal of struggling, which is injurious to the patient in many ways. These are the cases, in my opinion, in which mechanical restraint may be used with advantage. Then come those classed under the head of self-mutilation—perhaps a somewhat artificial distinction from the suicidal cases, but there is a distinction. I have had many cases of self-mutilation not distinctly suicidal, such as exhibit habits of flesh-picking, biting the fingers, or biting other parts of the body, pulling out hair, or eating rubbish. The other category of cases is that of sexual excitement, and self abuse in young women. The last is one in which I have the least hesitation in employing some means of mechanical retraint. It is essential, if possible, to stop the practice. I am satisfied that the keeping up of the practice of masturbation aggravates the excited condition of the patient, and that if one can break off the habit it is one's duty to do so, and there is, in my opinion, no method so effective as that of mechanical restraint. Of course that is not the only means. I am talking of cases which resist ordinary treatment, in which drugs and other treatment have failed. The illustrative cases I shall refer to presently are those in which ordinary means failed, and, as I believe, where no other means would have succeeded.

Case I., that of a gentleman who made persistent attempts to gouge out his eyes. Gloves were worn for seven days, with the result that the patient improved, and there was no return of the symptoms.

Case II., that of a lady, recurrent mania; the patient had had three previous attacks (not suicidal before) with delusions of fear and frenzy. She suddenly made a determined attempt to pull out her tongue, and was restrained by a sleeve dress for seventeen days. Result: rapid improvement; practically well in two months. Another attack two or three months later. Symptoms of acute mania. In two months very depressed and threatening suicide, and at the same time very violent and aggessive. She was placed in a side-arm dress for twenty nights. Result: rapid improvement and well in two months. Another attack nine months afterwards; not suicidal. Recovered in four months, and has kept well now for over four years.

Case III., that of a lady. Climacteric; delusions of fear and suspicion; hallucinations of hearing. There was a temporary improvement for a month or two, then a relapse into a condition of confusional insanity, with a tendency to violence. Much improved again after four months. Went to our Convalescent Home at Dawlish for a change. While there had a sudden outbreak of suicidal mania; tried to throw herself out of window and to cut her throat. Became very violent, refused food, and was exceedingly suicidal, with acute delusions of fear. For over two months she wore her arms confined by a sleeve dress; at first day and night, and after a time by night only. She then improved rapidly, and in three months appeared convalescent. That is the history of that case, so far as suicidal tendency is concerned. After two or three months another symptom occurred; she began to pick the skin off her face and arms, causing sores. For a month she wore padded chamois leather gloves at night, after which the flesh-picking tendency died away, and she improved steadily for six months, when she slowly relapsed, and the flesh-picking began again. For over a month the gloves were worn night and day, when the habit was again broken. Mental improvement was very slow, symptoms of insanity of doubt remaining for a long time. After a year improvement was more decided, but it was only at the end of another year that she was well enough to face the world again. She returned home in the spring of 1893, nearly five years after the commencement of her illness, and has remained perfectly well up to the present time.

Case IV., that of a lady with strong hereditary predisposition, suffering from acute melancholia. She was very depressed, excited, and violent to herself and others. Tried to injure herself in various ways, knocking her head, pulling out her hair, refusing food. Very aggressive, and if held, struggling most violently. She had many delusions. Six months after admission, restraint was first used in the form of padded gloves, to protect her, to avoid struggling, and to check self-abuse, to which she was much addicted. These were employed, more or less, for two months. General condition improved for about three months. Thereafter, constant refusal of food, struggling and trying to injure herself. She was reduced to a state of general prostration, and but for being restrained I believe would have sunk from exhaustion. Sleeve dress and side-arm dress

used on 78 occasions out of 106 days, at first at night, and during the worst of the attack for six weeks day and night, with intervals, and after that with longer intervals. After this improved for several months; relapsed again, but into a stuporose state. Just a year after the last attack worse again, refusing food, with self-abuse. Wore gloves at night for sixteen nights. After this quiet for another year, health failing. Then for a month refusing food, struggling, trying to injure herself, self-abuse. Was restrained at night for twenty days by gloves or side-arm dress. After this a good deal better for six months; then refused food again, and had to be fed by tube almost continuously for three months; remained quiet. Died suddenly from cardiac failure and a succession of fainting attacks nearly four years after admission.

Case V., that of a lady, suffering from acute delirious mania (strong hereditary predisposition) brought on by seeing her husband commit suicide. Very violent, refusing food. Ten days after admission tried to injure herself by putting her hands down her throat, &c. Was restrained at night by side-arm dress on 47 occasions. During this time improved very considerably, and did not again show suicidal symptoms, although the maniacal condition returned and remained chronic.

Case VI., that of a lady with no hereditary predisposition, suffering from melancholia. Intensely depressed and suicidal, refusing food; hears voices; anæmic; amenorrhœa. Was bent on suicide, and tried it in so many ways, that for three days of the week after admission she was restrained by side-arm dress for thirteen to eighteen hours. In the next two months improved a good deal, and suicidal tendency less acute. Then worse again; jumped over rail on top of steps. Improved a little again, but seven months after admission became most acutely suicidal; tried to smother herself, and to put herself on the fire. Was restrained for 27 nights by side-arm dress. After this slowly improved, and had no return of the acute symptoms, but remained depressed. Twelve months after admission had improved considerably, and was soon after removed to another asylum.

Case VII., a lady, religious melancholia; suicidal and homicidal. The patient attempted to smother the friend with whom she lived with a pillow; said she must kill her and then dash her own brains out. At the end of three

months she had considerably improved, when she was much upset by a letter, and in the night made a determined attempt to strangle herself with a garter and handkerchief, and was very violent after. The next day she attacked two nurses, and the following night tried to smother a nurse with a pillow; said she must kill someone. Then she wore gloves for 13 nights, improved gradually, and in three months was apparently well. Returned home in December, 1893, and has kept quite well since.

Case VIII., of a lady (puerperal), acute melancholia, suicidal, with hereditary predisposition. She developed persistent flesh-picking, causing sores on face, hands and arms. Gloves or sleeve dress were worn for six months. After improvements and relapses, finally recovered in two years, and has remained quite well.

Case IX., that of a young lady, with hereditary predisposition; mania; anæmia, and amenorrhœa. Had pulled out much hair; perverted appetite; ate anything, rags, sticks, bits of plants; tore up her clothes to eat. Wore gloves for eleven days with excellent moral effect. She begged to have them off; began to improve rapidly; in a month was convalescent, and in two more went home.

Case X. Chronic mania, with hereditary predisposition, admitted in 1886. From time to time there was a tendency to scratch and pick her hands, and in 1888 and 1890 she was troubled with an eczematous rash on her face. In January, 1891, the eczema, rubbing, and picking continuing, padded gloves were tried. After three nights her face was nearly well. Restraint stopped for two nights; patient as bad as ever. After nine more nights' restraint, face almost well; restraint stopped three nights; result as before. Gloves continued night and part of day for seven weeks. Had begun to rub her face with gloves; sleeve dress used. After a month her face was well, and restraint was stopped. Next day there was a large sore on one side of the nose. In six days well, and restraint stopped for nearly a week, when picking and rubbing face again began. Restraint resumed for three weeks and face again well. No recurrence of the habit for five months, when, without any eczema, she again began picking her face. For seven nights gloves were worn, and she was better. After an interval of eight days it began again. For two weeks gloves were worn at night, and the habit was completely broken. That was four years ago, and it has not returned since.

Case XI., a lady, admitted here in December last; hereditary predisposition, acute melancholia, addicted to self-abuse for months, worse lately. She was most intensely suicidal, and before admission had swallowed a bottle of liniment; tried to swallow some broken crockery; cut her wrists with broken crockery, and jumped over the banisters. The ordinary course was followed for six months, and she was very much worse, and after a time developed symptoms of acute nymphomania. Still suicidal, with most desperate struggling; in fact, it is the most exceptional and intractable case in my experience. From the 30th of May she has worn the sleeve dress confining the arms on 73 out of 130 days, about half of the time during the night and part of the day, and the rest of the time mostly at night. Since the end of July she has been under restraint only seventeen times, and for short periods during paroxysms of struggling and sexual excitement. That has been the case during the last six months, and it is very difficult to see in what other way she could have been managed. Two nurses, and sometimes three, could not restrain her, but, on her arms being confined, restraint in her paroxysms was comparatively easy. Every known drug, I think, has been used, and has been pushed freely. She is now quite as bad as on admission, and only yesterday attempted to commit suicide in one of her paroxysms.

Now, with regard to one or two points in conclusion. It seems to me that there are only three forms of alternative treatment. One is by manual restraint, the other is by drugs, and the third mode, which cannot be called treatment, is to allow the case to run its own course. I think that anyone who has seen exceptional cases, such as I have been trying to describe, must have a strong feeling that *something must be done to protect the patient.* Manual restraint, going on week after week, is not only impracticable, but very bad for the patient, leading to struggling and excitement just in the cases in which you want to conserve all the force and strength. In some, one is bound to use sedative drugs, but I would much rather do without them; and, given the choice between these strong medicaments and modified mechanical restraint, such as I have mentioned, I prefer the mechanical restraint. It does less harm in the long run, and if there is a possibility of recovery in the case

I think that the use of such drugs is more likely to retard or even prevent recovery.

Before sitting down I should just like to mention what may be considered to be the *disadvantages* of mechanical restraint. The first is that which I may, without being offensive to anyone, call to a certain extent sentimental. We all know that in the old days mechanical restraint was greatly abused, and that the great wave of improvement in the treatment of the insane was begun with the abolition of mechanical restraint. That influences our minds very much, and rightly. There is a feeling that it is demoralising to use modes of treatment which have been associated with such terrible evils in the past. But my opinion is that you have not said the last word when you have said that. I still think that, as physicians entrusted with the care of the insane, for whom we are bound to do the best we can, we must free our minds from the influences of tradition in regard to this matter; and that if we find a certain mode of treatment is useful in certain cases, we ought not to be debarred from using it by the fact that it has been abused in the past, or that it is officially discouraged in the present. Another disadvantage is that there is a temptation to keep it up too long. Certainly that is true. A similar argument applies to drugs or any means of restraining treatment. I do not think there is any greater possibility nowadays of using mechanical restraint in excess than there is of using drugs to excess; I hardly think so much. The third disadvantage is in the possibility of producing a bad moral or physical effect on the patient. My experience is that such fears may be disregarded. I cannot recall a single case in which there has been any bad effect, either bodily or mental. I have never heard patients complain afterwards of being restrained, while some are thankful for the restraint. I have heard them beg to have the gloves taken off, and to be freed from restraint, and so on, and that is a very powerful lever, especially where you can work on the patient's self-control.

I will now tabulate shortly what I consider to be the *advantages* arising from the use of mechanical restraint in these cases. The first is that there is greater security for the patient. You feel that you are doing your best and your mind is more at rest; you are able to check injurious habits, which it is extremely difficult, if not impossible to do—that

is my experience—in any other way. And then it is first of all constant; it does not relax in vigilance; it does not lose its temper; and these, I think, are very important matters. I think we are all inclined to expect too much from attendants and nurses. They are but human, and it is impossible to conceive anything more trying than the duty of preventing these patients from injuring themselves, of restraining them in struggles, and at the same time keeping a good temper and doing the duties imposed with anything like coolness. We are justified, I think, in cases of this sort in thus assisting the nurses and attendants in a way that does not go against the conscience, and in a way that does not do harm to the patient. Then a very great advantage is that it certainly husbands the strength of the patient, by preventing exhausting struggles and limiting the use of sedatives. That, to my mind, is the greatest advantage of all. Another is, I think, in some exceptional cases, that it tends to more real freedom for the patient in the way of exercise, the patient who is restrained in a modified way, such as I have described, being able to get out and move about.

Now I have come to the end of what I had to say on this subject and it only remains to invite suggestions and comparisons. I should like to know if any of you meet with exceptional cases of this sort, and the means that you adopt in treating them. My opinion is that the circular lately issued to us with regard to the use of mechanical restraint is one of the very feeblest productions that ever came from any responsible body of Commissioners. It is neither one thing nor the other: it tries to run with the hare and hunt with the hounds. If the Commissioners think what they profess to think, why do they not propose an enactment that mechanical restraint shall never be used? They know perfectly well, as well as I do, that if they were to succeed in having such a thing enacted, it would be absolutely impossible to carry it out. If we concur in such recommendations, we go far to invite suggestions as to the doses of medicine to be employed. We may even be within measurable distance of not being allowed to give some drugs at all.

My object in opening this discussion is that there should be a little more common-sense utilised in dealing with this subject, and that we should, at any rate, try to keep an open mind on the question.

Discussion on Dr. Deas' Paper.

Dr. WEATHERLY cordially agreed with what Dr. Deas had said with regard to suicidal and self-mutilating patients, but he was surprised to hear that restraint was only useful in cases of self-abuse in women. His experience had been absolutely the reverse. He had had a very lengthy experience of cases of masturbation in women. One case had been under his care for fifteen years, and another for a considerable time, and he candidly admitted that mechanical restraint for preventing masturbation in women was most unsatisfactory. Rubbing the thighs together was one, he thought, of the commonest forms, and how they were to stop that by a long sleeve jacket he failed to see. Dr. Langdon Down had a large number of these cases under his care, and he understood that the only means he (Dr. Langdon Down) believed could stop the practice in women was absolute constant supervision, and when the masturbating fit came on to immediately apply cold ice pads or cold water to the parts. He (Dr. Weatherly) had tried that in one case with a good deal of benefit, but the case left the hospital at the instance of her friends. With regard to masturbation by men, he thought here they certainly had a class of cases in which nothing, unless it was allied to mechanical restraint, would do any good. He had one case, especially, that he should like to bring before their notice. He had been in a London Asylum for acute mania, and came to him an absolute wreck. He could not say one coherent sentence; messed about his food; looked like an idiot; masturbated incessantly; defecated in his clothes; ate his motion, and in fact a more filthy patient he did not think he ever recollected seeing. He (Dr. Weatherly) tried all ordinary methods to stop his habit of masturbation without success, and then wrote to the Commissioners that the only hope was continuous mechanical restraint in a long sleeve jacket. They replied that he must take the responsibility; if it was a right and proper thing he ought to do it. That was before the mechanical restraint book came in, although it was in use before the man was well. For six months he was so restrained, and gradual improvement became permanent. He did not think that man's recovery could possibly have taken place without mechanical restraint. There was a class of cases which Dr. Deas had not touched upon, and which they had all no doubt had to deal with. He referred to those whom they could not keep in bed. They would be up all night, hammering at the doors and banging at the walls, until a condition of exhaustion supervened. He had one case in which he had had to bring the patient back from impending death with injections of sulphuric ether. He had in the case of a lady—the case of chronic masturbation which he had already mentioned—used the simple expedient of a sheet round the patient, properly fastened when in bed, and there had since then been no difficulty; she had remained in bed. She was getting thin, her heart was beginning to fail, and what he was to do he did not know, if such a simple measure as placing a sheet round her might not be used. If she was in a room with a nurse she was fighting all the night. Without the sheet he did not know how she was possibly to get that amount of rest absolutely required to keep her alive.

Dr. WADE said he had seen two cases in which mechanical restraint cured outbreaks of violence when nothing else would have done so. In both it might truly be said that the precaution was certainly taken for the benefit of the patient. He had a patient who always attacked anyone who came into the room, and as a result he was being knocked about by the other patients. He was in very bad health, and could not possibly be reduced further by drugs. He decided to restrain him and used a belt with the arms fastened to the sides. He released him on several occasions, but prematurely. After several months of this treatment, however, it proved successful. That was eight years ago, and he had not resumed the habit. While the man was walking about wearing the belt the visiting Commissioner was Mr. Cleaton, who remarked "I am glad to see it, and glad to see you have the courage to do it." The other case was that of a girl who flew at the nurses from behind, caught hold of them by the hair and pulled them down. She wore a jacket with the sleeves down to the elbow sewn to the side

and was thus completely broken of the habit. It was a remarkable fact that the means of restraint used in both these cases was now absolutely illegal, and it would be necessary to put on a strait-jacket, which entailed a great deal more restraint than that adopted. According to these new rules, if a patient was put in a strait-jacket he must be visited every few hours by the medical officer. As far as his experience went, such cases chiefly required restraint at night. Was the medical officer who had a case or two of this kind to be rung up every two or three hours during every night? That would have to be done to conform to the rules. and rendered it impossible to apply restraint when most required.

Dr. BENHAM wished to congratulate Dr. Deas upon the very able way in which he had brought the subject forward, and to say he thought they were all generally in agreement with him that mechanical restraint was occasionally useful. They would all probably admit that in public asylums like his own they had very much less occasion for it than in private asylums; but they had to use it occasionally, and he had had two or three cases in which the patient's life was saved by mechanical restraint having being used. Dr. Benham mentioned a case in which a woman had put her hand into her vagina and torn it out. His colleague, Dr. Aveline, succeeded in patching the parts together. The woman was restrained for some weeks afterwards, and eventually recovered. They had other cases, such as face-picking, partly restrained by means of gloves. Some had recovered. and others had proved intractable. But while he was in favour of mechanical restraint he thought it ought only to be used under stringent medical supervision. With regard to what Dr. Wade had said about supervision at night, he supposed every Superintendent would use his own discretion. If a very bad case was under treatment probably the assistant medical officer would see the patient as late in the evening as possible, and the case would never be left by the nurses, who would report anything exceptional at once. In the ordinary course, without such a report, the case would not be seen again until next day. He did not think human nature could tolerate constant visits during the night. He had been particularly interested in what Dr. Weatherly had said about Dr. Langdon Down's treatment. His method of treatment was practically that the patient should be accompanied everywhere, especially to the water closet, and that ice should be kept at hand and applied at once to the part affected as required. Dr. Langdon Down had told him that he had successfully treated many cases in that way. One of the means used by him was to provide strong huckaback drawers, constructed on the principle of children's drawers, without an opening. These they had found a very effective means of stopping the habit, but, of course, in a public asylum they were at a disadvantage, as they could not give that individual care and attention which could be obtained in private asylums. It might be said for most of them, however, that they did the best they could to restrain habits of the kind mentioned. When nurses and officers found that mechanical restraint saved trouble, they would be found willing to adopt it, and for a long time to come it would probably be difficult to avoid extremes, so that a wise and efficient supervision was necessary. At the same time, as far as he could see, until some new method of treatment arose, they would require to use mechanical restraint in rare and difficult cases.

Dr. MACDONALD did not think there was much difference of opinion with regard to these exceptional cases, but he still was strongly of opinion that the less restraint they used the better. He was quite certain they were influenced by representations from the staff, and sometimes very justly so. They expected to get faithful reports from their nurses and attendants, and he knew from his experience that if they had a leaning towards the use of exceptional means. the medical officers would occasionally be moved, even against themselves. to adopt it. All the time he had been in the present home of his labours he had only once used mechanical restraint for any length of time. In that case an ordinary long-sleeved jacket was worn for the prevention of self-abuse. He would not use mechanical restraint in cases of dirt and rubbish-eating. The nurses and attendants ought to be able to prevent that if they were doing their work. But Dr. Deas, although putting the case strongly, had so

guarded himself by pointing out the errors and dangers, that there was little upon which they could disagree and he most heartily seconded Dr. Benham's expression of thanks for his so ably bringing the subject before them.

Dr. ALDRIDGE said the cases that had been brought before them were certainly very exceptional. He had only one entry in his restraint book in five or six years. That was a case in which he had to use a sleeved jacket on three or four occasions, for face scratching. The old lady so treated occasionally became very violent and scratched her face until the blood ran down in streams, and there was a terrific struggle to prevent her self-inflicted injuries. The sleeved jacket, however, enabled her to walk about for two or three hours till the attack passed off. He remembered having a case fifteen or sixteen years ago, who was dreadfully suicidal. She was restrained in the same way so that she could more easily be managed. The third case that occurred to him was the wife of a sea captain, who had thrown her child out of a port-hole. She was very homicidal, and her husband had devised a form of restraint which she wore as a muff, there being straps under. She brought this with her, and on two or three occasions when she felt the tendency coming on she begged to have it put on, and it was put on for a few hours. She afterwards went to a county asylum, and he did not know what had become of her since. Patients were actually grateful for being restrained. One of the cases he mentioned proved that.

Dr. DEAS, in reply, said that he had been under the impression for many years that it was one of the most difficult things to restrain a man from masturbation by mechanical means. There had been all sorts of ingenious devices, quasi-surgical, &c., suggested for the purpose. He could not see how wearing long-sleeved jackets would prevent a man from masturbating. The patient would turn on his face and effect his purpose. How would that be stopped?

Dr. WEATHERLY said the man could be turned on his back at once if the case was always under observation.

Dr. DEAS could quite understand that, but he at first gathered from Dr. Weatherly that he was of opinion that mechanical restraint alone would prevent it. That was quite contrary to his experience, and that was why he did not allude to it. With regard to women, he had been only stating his own experience, but perhaps it ought to be taken into account that the cases in which he had used mechanical restraint were not so much the chronic cases as those acute outbursts which occurred especially in young girls and puerperal cases, and his experience was that in those cases the hand was the offending member, and that if the hands were confined they practically stopped it until the period of excitement was over. He was rather inclined to agree with Dr. Weatherly with regard to the cases of extreme restlessness at night. As to what Dr. Macdonald had said with regard to the staff, he thought they would be placing themselves too much in the hands of their officers if it was recognised that mechanical restraint would be applied if only a strong enough report was made. A remark by one speaker led him to add that he thought he had not sufficiently emphasised one point, and that was that in some of these cases it was necessary to continue the treatment for some time. They must persevere and not be discouraged after a short trial, and in a great many instances they would succeed with cases which at first seemed practically hopeless.