able now to establish such a Register. Difficulties, such as finance, the extent to which nurses would adhere to its requirements, and so forth, were realized. Nevertheless it was resolved, "That, in collaboration with the Minister of Labour, steps be taken with as little delay as possible to draw up a live Register of Mental Nurses, and to establish it."

The Reports from our Parliamentary Agent have been regularly received and found valuable.

Amongst other mental matters mentioned in Parliament the Committee has noted the following: The Minister of Health has reported that the general health of the nation has been better than in peace time; contrary to expectation, war strain and bombardment have not increased mental disorder, and in 1940 there was a decline of 2,000 in cases of mental affection requiring institutional admission, and this same decline continued in 1941; deaths in mental institutions have risen from 6 per cent. of the average daily number of residents in 1938 to 9 per cent. in 1941; mental deficiency shows a similar rise (although here the basic figure of deaths is, of course, only one-sixth of that in mental institutions); tubercular deaths have risen steeply and continuously, males showing the higher proportion (the Parliamentary Committee scrutinized this report for statistical modification); the relationship of epilepsy with military service is still under examination, also that between health breakdown and attributability for war pensions; mental disorder has not proved prominent in this.

The Committee is watching, amongst other matters, legislation for enrolment of new classes of assistant nurses, dust lung-damage, pasteurization of milk and that for new war-pensions appeal tribunals. Despite internal criticism, the Government are adhering to their venereal-disease legislation, stimulated thereto by a medical Member's statement that these afflictions cause 15 per cent. of London-area hospital admissions.

The Minister of Health announced that the voluntary hospital system will be continued, medical men compensated for loss of practice, and that, despite previous intimations, mental hospitals may be included in the Beveridge Scheme. A dispute is proceeding between the relevant Department for providing mental and other medical officers to the Army, which asserts its inability to provide more, and the Army Council's insistence that it must do so. Wages of mental hospital workers are being inquired into.

The Beveridge White Paper is expected in September.

He moved that the Report be adopted. Dr. C. Bower seconded, and this was agreed.

REPORTS OF SPECIAL COMMITTEES.

(*a*) Handbook.

The President said that a report on the progress of the Committee was received by the Council, but there was no report to be made to the Association; the work was proceeding.

(*b*) Medical Planning Committee.

Dr. Gordon Masefield presented the Interim Report of the Medical Planning Committee, which had been circulated.

Interim Report of the Medical Planning Committee to the Council.

This Special Committee was appointed by the Council in July, 1941, with the following terms of reference:

"To keep the Association informed of the reconstruction and progress of Medicine, with particular reference to Psychiatric Medicine."

The Committee is composed of the principal officers of the Association with power of co-option. The following Members have been co-opted.

Drs. R. Sessions Hodge, T. P. Rees, W. McCartan, I. Skottowe, C. Bower, C. J. C. Earl, B. W. F. Armitage and J. J. O'Reilly.

The Committee has met on ten occasions. Memoranda on different aspects of the reconstruction of the Mental Health Service have been issued by Drs. A. A. W. Petrie, F. Douglas Turner, T. P. Rees, I. Skottowe and W. Gordon Masefield, and considered by the Committee. The Committee has also referred to the B.M.A. Report of Committee on Mental Health.

The Committee recommends:

General.

1. That Mental Health Committees be formed in each Area throughout the country as may be decided hereafter by the Government, such Committees to be responsible for all aspects of Mental Health, i.e. to take over the work of Committees of Visitors, the Committees under the Mental Deficiency Acts and the Child Guidance Clinic Services. Mental Health Committees should consist of elected and co-opted members. Close co-operation should be maintained between these Committees and the Public Health and Education Committees.

2. That a Medical Advisory Committee fully representative of those practising Psychiatry should be set up in each area.

3. That large areas are preferable to small areas. Each area should be of sufficient size to warrant the setting up of a complete Mental Health Service.

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4. That all matters appertaining to Mental Health Administration should be removed from Public Assistance.

5. That the present name of the Board of Control be changed to " The Board of Mental Health." The powers of the Board of Mental Health should be extended to enable it to supervise and direct all branches of Mental Health in its widest aspects, many of which are at present administered by other departments. That there should be a larger body of medical representation on the Board of Mental Health.

6. That a Medical Officer of Mental Health should be appointed in each area. He should be a principal Officer with clinical and administrative psychiatric experience. His task should be the co-ordination of all branches of Mental Health. He should have equal status to that of the Medical Officer of Health, with whom he should work in close collaboration. He should be appointed by the main Mental Health Committee after consultation with and with the approval of the Board of Mental Health. His security of tenure should be similar to that of a Medical Officer of Health.

7. That a Medical Superintendent should be in charge of each Mental Hospital and Mental Deficiency Institution. He should have complete control and should be in continual touch with the clinical aspects of the Hospital and its patients. Any arrangement of Staff by which dual authority tends to be established in the central government of either type of institution is emphatically opposed.

8. That in each Psychiatric Hospital and Institution it is desirable that a Medical Board should be set up, of which the Medical Superintendent should be the Chairman. This Board should comprise all the Medical Officers with suitable experience and representatives of the Consulting Staff.

9. That it is essential for the proper understanding of all cases, including those of Somatic Disease, for Medical Students to be taught a suitable Psychology in the Intermediate stage as well as the principles of Psychological Medicine in the Final Course. At least one question on Psychological Medicine should be asked in the General Medicine Examination. Teaching and Examining Bodies should be urged to raise the standard in clinical experience of Psychiatry to the level of the kindred subjects of Medicine, Surgery, Obstetrics and Gynaecology.

10. That there should be a unified system of Social Service. All Psychiatric Social Workers should receive such training as will fit them for service in all branches of the Specialty.

11. That Lay Psychologists should be employed more extensively and greater opportunities for their clinical training should be provided.

12. That no Mental Hospital or Mental Deficiency Institution should be set aside solely for Chronic Psychotic cases and/or Low-Grade Defectives except possibly for Senile mental persons.

Psychoses and Psychoneuroses.

13. That dependent on the area and density of the population to be served Mental Health Services should be supplied by means of the Mental Hospital and Psychiatric Units—that part of a General Hospital which is set aside for the treatment of Mental Disorders, whether In- or Out-Patient Department, should be known as a Psychiatric Unit.

14. That a number of beds, approximately 6 per cent. of total bed accommodation, should be available in each General Hospital where an Out-Patient Clinic is held regularly, provided that the Hospital has an adequate Staff of Mental Nurses trained and in training.

15. That in larger Centres (especially University towns) special Psychiatric Units will, it is hoped, be established, with facilities for both Out-Patient and In-Patient treatment, Teaching and Research.

16. That the Mental Hospital must be the Main Unit for the provision of In-Patient Services and must be maintained at the maximum efficiency in Staff and Equipment. Both the Medical and Nursing Staffs should be increased by at least 50 per cent. over pre-war standards. All the members of the appointed Medical Staff should take some part in extra-mural duties, e.g. Out-Patient, Convalescent (Rehabilitation) Homes and in a Consultative capacity at Health Centres. There should be posts for Clinical Assistants at all Mental Hospitals. These should be taken up after the usual House Officer appointments have been held in a General Hospital. Before a post on the Medical Staff of a Mental Hospital is obtained it is desirable that a Medical Officer should have experience in General Practice.

17. That Registered Hospitals and, in Scotland, the Royal Asylums should continue to carry out their present functions, but if it becomes clear that some alteration is necessary, consideration should be given, in consultation with their Governing Bodies, to the utilization of some such Hospitals for Post-Graduate study and special lines of Research, possibly in association with Medical Schools.

18. That Licensed Houses will continue to serve a definite purpose in providing beds for " Private " patients, and that therefore such accommodation must be fitted into the scheme for a Comprehensive Medical Service.

19. That amendment of the Mental Treatment Act (1930) is urged so that under Section 5 all Non-Voluntary first-admissions may be received for the purpose of treatment and detained for a period not exceeding six months, with possible extension by the Board of Mental Health, without a Reception Order. This involves the omission of all reference to " willing or unwilling to receive such treatment."

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20. That the treatment in a Mental Hospital and its Ancillary Services and Units of all forms of Neuroses and Psychoses should be generally recognized, there being no fundamental scientific difference between the Psychoneuroses and Psychoses. The distinction for practical purposes is to be found in the degree of disorder and in changes of conduct and sensitivities of patients. That wherever a patient be treated the treatment should be provided by the associated Staffs of a Psychiatric Hospital or Unit or other recognized Psychiatric Consultants.

21. That special legislation and accommodation is required so that Drug and Alcoholic addicts may be detained under some form of Order for periods sufficient to permit adequate treatment.

Dr. MASEFIELD said that the Committee had met on 11 occasions, and the 21 recommendations in the Interim Report dealt with the future treatment and administration with regard to psychotics and psychoneurotic patients. A further report dealing with mental deficiency would be produced to the Association later (see p. 18). The document before the meeting had been approved after amendment by the Council, and it was hoped that the Association would allow it to go forward to the Minister of Health, a copy to the Board of Control and the General Board of Control in Scotland, as an agreed document of the Association. He moved accordingly.

The PRESIDENT seconded the proposal.

Dr. LINDSAY said that in the absence of Dr. Douglas Turner he felt it was very cavalier treatment to refer back the mental deficiency part of the Report. This part was as important as the other, and it would be put off for a long time.

Dr. MASEFIELD said that the Council at its meeting last evening was convinced that the mental deficiency part of the Report was as important as the rest, and felt it was desirable not to hurry it through. This was the only reason why it had been decided to refer it back to the Mental Deficiency Committee for their comments before placing it before the Association.

Dr. CLIFFORD M. SCOTT said that very little was said about child psychiatry in the Interim Report.

The PRESIDENT said this would be dealt with by the Mental Deficiency Section.

Dr. SCOTT said he understood there was a Child Psychiatry Sub-Committee in the Clinical and Research Committee. Would that Committee deal with it?

The PRESIDENT said that the Mental Deficiency Committee would deal with it.

Dr. SCOTT said that the Report was presented to the annual meeting without the detailed discussion which could explain such recommendations. There had been various conversations going on and the Minister of Health had had various memoranda before him. He thought the Association should be able to put before the Minister of Health a much more adequate summary or Report than the present document. Was there any way in which an exposition of this report could be put before him?

Dr. SARGANT said that if the Report was sent to the Minister he should be made aware of the composition of the Committee. Apparently the members of Council were *ex-officio* members and certain members had been co-opted. He did not see any member or co-opted member who worked in a mental hospital below the rank of medical superintendent; he saw members working outside mental hospitals, but did not see any representative of the ordinary clinician. He believed psychiatry could progress in the face of bad administration, but it could not progress in the face of bad clinical work. He thought some interest should be taken in the people working in the hospitals below the rank of medical superintendent.

Dr. E. C. DAX asked if the meeting was expected to accept this report without any chance of having a longer time to read it through or to discuss the matter more fully. There were many points which might be raised. There might have been more time given to discuss the matter. It was not quite clear how the representation of the Association to the Minister was to differ from that of the British Medical Association, and if the Report was to be something in the nature of a parallel document, surely they should produce something in a document which was parallel in detail and which investigated the whole service.

Dr. ROSE said that if the Mental Deficiency section was to be referred back to the Committee, so also should the Report now before the meeting. He believed that the larger report framed by the B.M.A. Psychological Medicine Group had also been referred back so that they need not press forward with any fear that they would be too late. He suggested that the adoption of the Report should be postponed until the members had had an opportunity for further study.

Dr. R. M. STEWART said it would be a pity if the members of the Association felt that this Report was going forward without any opportunity for them to discuss it. As Dr. Sargant had pointed out, there were different views in the Association which were bound to be raised. It was a small report compared with the B.M.A. Report, but they ought to be able to produce a slightly larger document.

A MEMBER felt it might be a good idea to have a special general meeting of the Association at some date in the near future when it could be discussed by both junior members and medical superintendents.

Dr. BURKE said that there was some urgency that something should be presented to the Government so that discussions on the White Paper should not be taking place in the absence of mental experts. The report of the Psychological Medicine Group would not be accepted yet as a B.M.A. publication, but they had an undertaking that it would be presented to the Ministry as a statement of the views of the Psychological Medicine Group. What that Report put forward

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in a rather longer form was similar to the report under discussion. They had to be guided by the Parliamentary Committee and the Council as to the urgency of getting some views before the Government, and whether they should forego the opportunity of discussing the Report carefully and getting the mental deficiency section into it.

Dr. LINDSAY said that the Minister had stated he was prepared to accept documents from any reputable body qualified to express opinions, and that body would then be asked to send a deputation to explain its document. He was strongly of the opinion that this document should go forward plus the Mental Deficiency section.

Dr. GILLESPIE said he wondered whether it would be possible to have more discussion from the point of view of education. He imagined the Minister was informed about the Association, and one of the outstanding things in this war was that there was a kind of subdivision in training in psychological medicine. On the one hand there was the man whose experience was mostly from a mental hospital, and on the other there was the man whose experience was entirely outside. He did not think this was a desirable state of affairs; it gave rise to criticism of both types of training. Any report of this sort should have that in mind.

Paragraph 12 might be amplified in some way to ensure that in future, as far as possible, everyone who aspired to other than administrative duties in this branch of medicine should have as comprehensive a training as possible, and that no one would seek to practise psychological medicine without taking a residential post. The majority of patients one saw at present, whatever might happen in the future, did not reach mental hospitals, and did not belong to the type of material usually seen there. The reason for this was that alone of all the countries of western civilization British hospitals had failed to develop psychiatric units. If this was to happen in future no one's psychological education should be considered complete unless he had held a post in one of these as well as in a mental hospital. Could something be done to make that clear?

From another angle it seemed that there was an opportunity for a recommendation that wherever there was a psychiatric unit in a district, the medical superintendent of the mental hospital should be joined to the unit in at least a consultative capacity, and should be on the senior staff of a teaching hospital. He wondered if a reciprocal arrangement would not be possible, because one of the bad things about consulting practice was that, as things stood to-day, as soon as one was appointed to consultant rank one lost a considerable number of beds, and this was a serious drawback in every way. If some regional arrangement could be produced or recommended whereby the person in charge of the local psychiatric teaching unit in the general hospital might be on the visiting staff for teaching purposes of the mental hospital it would be an excellent thing.

He would like to see these points incorporated if possible.

Dr. AUBREY LEWIS thought this Report should be adopted and sent in. In answer to Dr. Gillespie, many cases of psychoneuroses had to be dealt with by the medical staff of the mental hospital, and they would welcome the opportunity which would be given to them to have further experience and training in the handling of these cases. It was true that a consultant lost beds and the seriousness of that was realized, and mental hospital staffs would welcome the visitation of outside consultants, but if this scheme were finally adopted, people acting as medical officers of mental health would be people of consultant standing. It would be much better to get something forward now rather than defer the report to a later date.

Dr. HULL supported the point made by Dr. Burke. He thought the report should be complete. The time was rapidly coming when there should not be a division between the mental deficiency service and the mental hospital service. The profession should fuse the two services into one.

The PRESIDENT said the Minister of Health was anxious to receive advice from those who were competent to give it. The Government was formulating a White Paper to be issued in September. It was now July; the month of August was before them. Did the members wish to have a special meeting in August to consider this report? He regretted very much that the issue had to be forced in this way; there were other bodies interested in this work; one had already consulted its constituent bodies, and the other was obtaining the full imprimatur of its members. The R.M.P.A. was the only Association which could place its views before the Minister with a view to affecting the White Paper, and he must ask the meeting to decide whether they would postpone it. It had been proposed and seconded that the Report be referred back to the Association for further consideration at a special meeting. He would ask members to vote upon that proposition. There voted:

In favour . .	21
Against . .	29

The PRESIDENT then put the proposition that the Interim Report be adopted, which was agreed.

Dr. LINDSAY asked if the Mental Deficiency Report could be taken. He suggested that the document which had already been drawn up could be forwarded with the other report.

Lt.-Col. MCCOWAN said that the subject for discussion at the meeting in November was medical planning. It would be interesting to those who had lost the vote to know whether, if anything happened at the November meeting which might alter the document, it would be mentioned to the Minister on any subsequent date as coming out of that meeting.

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The PRESIDENT said that the White Paper would provide a basis which would enable them to build very much more satisfactorily than in the past. The fact that they had been able to secure agreement on some points would be commented upon. They would be glad to discuss the matter at the November meeting and modify any views which might be put forward now, and take them to the Minister if possible.

Lt.-Col. PETRIE said the report was labelled "Interim Report," and it was being sent forward now to ensure that some proposals were put forward. They would be elaborated later, but this was a succinct set of proposals so that the Minister could know what the Association thought. He understood that it would be made clear that the Mental Deficiency Section would follow. There was a feeling at the Council meeting that it should be carefully edited, especially with regard to child psychiatry, and they wanted to have it in proper form so that it would represent their views sanely and soundly to the Minister.

Dr. LINDSAY submitted that the Mental Deficiency part of the Report was as carefully drawn as the other, and he felt that it should go forward as it was to complete the report.

Dr. FRIEZE STEPHENS asked if it had been before the Mental Deficiency Committee. If not, how could it be put forward?

Dr. LINDSAY said that it was drawn up by the Planning Committee of the Council, and the Mental Deficiency Committee had no more right to discuss it than other committees other parts of the plan.

Dr. ROSE said that the Mental Deficiency Committee felt confidence in the Planning Committee and the Council and many were anxious that this part of the Report should go forward.

Dr. STEWART said there was evidently disagreement on this point. Some felt there was no urgency to send one part of the report. He thought it was wrong to send only one part of the Report; if it was urgent to send in a report surely they should send in the full report, not just a part.

The HON. SECRETARY reminded the meeting that it had taken 18 months to produce the Interim Report, and the present form of the Mental Deficiency Report had taken two meetings, and it had not been properly considered.

Dr. LINDSAY did not agree with the Secretary's remarks. The Mental Deficiency Committee gave it their moral support. He asked the Chairman to take a vote.

On being asked for a definite proposition, Dr. LINDSAY moved that the Mental Deficiency Report should go with the rest of the Report.

Dr. STEWART seconded.

Dr. GILLESPIE asked if the report on child psychiatry was going forward under the heading of "Mental Deficiency." He thought that was very unfortunate.

Dr. PETRIE asked if the Report was before the meeting. He thought the only people who had seen it were members of Council.

Dr. FRIEZE STEPHENS said the Report had never been before the Mental Deficiency Committee. It should go before that Committee and then before the Council.

Dr. BURKE asked if there was any intermediate course which could be taken.

The PRESIDENT said that Dr. Lindsay stated the Report was in order, but certain members of the Mental Deficiency Committee and others considered that they should see it first and that apparently was the point at issue. This was the reason why it had not been placed before the Association at that meeting. His view was that after it had been taken to the Mental Deficiency Committee it would be respectable, and they could take it with them and say it had not been before the whole Association, but had been considered by the Council and Committee, and they were bringing it forward as an Interim Report which had not been fully discussed as a whole by the Association. That was the next best thing to do, having regard to the shortness of time.

Dr. LINDSAY said that applied to the whole of the rest of the Report. ("Hear, hear.") There was no reason why the Mental Deficiency Report should not go forward.

Dr. SARGANT said that he had already pointed out that not one single ordinary member was represented on the Committee, and there had not been any discussion upon the Report.

Dr. FURNISS proposed that both reports should be forwarded, or both should be deferred.

Dr. LINDSAY said his proposal was that the Mental Deficiency part should go forward with the other part.

The PRESIDENT said that the Association had not seen the Report. It would be circulated to the members and discussed later in the day.

The meeting then proceeded to the next part of the business, and later in the day the matter was further discussed.

Mental Subnormality including Mental Deficiency.

22. That the problem of Mental Subnormality and its social consequences is undoubtedly a far wider one than has been generally recognized.

23. That the present Legal and Administrative procedures need revision:

(*a*) To remove the existing confusion and anomalies whereby Defective Children are dealt with in several different ways under four different Authorities.

(*b*) To remove the difficulties of bringing under suitable care and training Children who are first seen between the ages of 14 and 16.

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(*c*) To enable any Subnormal Child to receive without strict formality or Legal Certification such Special Education as may be necessary.

(*d*) To provide for the whole group of the Subnormal rather than for the restricted portion who are Certifiably Defective.

(*e*) To provide that a Certified Institution may, when advisable, admit patients on a "Voluntary" basis on the application of a Relative and one Medical Recommendation as in Section 1 of the Mental Treatment Act, 1930, and also in conformity with Section 5 of this Act on a Temporary basis.

24. That the Medical Officer of Mental Health, if not sufficiently experienced in Mental Subnormality, should be advised by a recognized Specialist in this field.

25. That the entire Service of the Subnormal should be transferred from the Public Assistance Authorities to the Mental Health Committee.

26. That for the Retarded Group an increased number of Special Schools, both Residential and Day, are required. More Occupation Centres should also be established.

27. That Residential School treatment under Psychiatric direction should be made available for Maladjusted Children, preferably by Voluntary admission.

28. That Approved Schools at present under the Home Office should be directed by the Board of Mental Health.

29. That community care of the Retarded Class and Licence from Institutions should be widely extended. All large Institutions should have several Branches, both for use as Hostels and for Training and Rehabilitation.

30. That in each area there should be provision for a period of Observation by Temporary Residence in a Special Unit or in an existing Institution before Certification as a High-Grade Defective. Admission to such Units should be on a "Voluntary" basis in the case of Minors or on the Order of a Magistrate or other Official approved for the purpose by the Board of Mental Health, and should not be for a period exceeding six months. That no Medical Practitioner without special experience and qualification should be empowered to certify Mental Deficiency.

31. That all Medical Officers employed in Mental Deficiency Colonies or Institutions should have opportunities for extra-mural duties in order to maintain and increase their interest and to provide the essential Specialist advice in Schools, Clinics, and Hospitals.

32. That Medical Officers working in the field of Mental Subnormality should maintain close co-operation with the School Medical Officers so that consultations may take place in regard to educability and ascertainment.

Child Psychiatry.

33. That the Child Psychiatry Service is an integral part of a Mental Health Service. Child Guidance Clinics with associated In-Patient facilities are required in every area, and should be under the management of the Mental Health Committee working in close co-operation with the Education Authorities.

34. That as an important prophylactic measure there should be systematic Psychological Examinations of each School Child. These Examinations should be primarily the province of the Educational Psychologist, selected cases being referred for full Psychiatric examination as required.

35. That all Delinquent Children should be examined by a Psychiatrist, whose report should be available to the Court.

The PRESIDENT said that the Report had been circulated and no doubt members had read it.

The question was whether it should be embodied with the Interim Report and sent to the Minister of Health before it had been seen by or reviewed by the Mental Deficiency Committee. Did Dr. Lindsay or Dr. Stewart wish to press the matter further?

Dr. LINDSAY said that a suggestion had been made that the Secretary should edit this part of the Report and incorporate it in the Report to be sent to the Minister. He had already told Dr. Masefield that he would have the utmost confidence in his doing so.

Dr. MARSH said that if this was a proposition he would second it.

Lt.-Col. MCCOWAN, speaking as a member not specifically interested in deficiency, asked whether it would be possible for the Secretary to take out the parts referring to child psychiatry, and make it clear that it was not the feeling of the Association that child psychiatry was a branch of mental deficiency. He was willing to agree to the proposal if that were done.

Dr. LINDSAY said that had been considered. The idea was that they had not found the right name, but they would introduce another name for this branch of psychiatry so that mental deficiency would merely be a branch or a section of that other branch of psychiatry. It would make the mental deficiency work much more interesting, the officers of mental deficiency institutions would be able to get out of their institutions and be able not only to spot a large proportion of mental defectives, but they would find life much more interesting.

Lt.-Col. PETRIE supported Dr. Lindsay. There was a suggestion that this section should be labelled "Child Psychiatry and Mental Deficiency." Essentially mental deficiency was one of the sections of child psychiatry which embraced an even wider thing; it embraced the question of the normal child, the maladjusted child and the defective child. This was slightly referred to

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in Section 17. Dr. Gillespie had made a point about throwing this into the hands of the female psychologist. It was a vexed and delicate question, and it was the slight reconstruction and placing of one or two of these points which made some of them feel that the report needed a little more checking.

Dr. KIMBER said that the Child Psychiatry Sub-Committee had had no part in submitting a memorandum on this point, and to expedite the forwarding of this document he suggested that that Committee should receive from members of the Association their views on the subject and incorporate them in the report before it was submitted to the Ministry at the discretion of the General Secretary.

Dr. LINDSAY said Dr. Kimber had raised the hare which everybody had raised; the Association had not considered it, the Mental Deficiency Committee had not considered it; why should the Child Guidance Committee have an opportunity to do so?

Dr. KIMBER said that he was merely asking that a certain section should be allowed to express an opinion on these points.

Dr. T. P. REES said they should be dealing with main principles, not details. The only principle now was whether child psychiatry should form part of a comprehensive mental health service. When Dr. Masefield had dealt with this it would be one report which would include mental deficiency and child psychiatry.

Dr. C. W. BOWER stressed one other reason why this report should go forward very soon. This matter was very much mixed up with education. The Educational Reconstruction White Paper had already come out, although it did not refer in any way to any matters connected with mental deficiency. He understood that the reason was that the mental deficiency question regarding education was still under discussion, but it probably would not be for very much longer, so that if they had any advice to give as to the future treatment of mental defectives which might impinge on the educational side, it was exceedingly important that their recommendations should go not only to the Minister of Health, but possibly to the Minister of Education. If their recommendations were to have any value they should go in quickly.

Dr. BURKE said that he had it in mind to propose a reference back, but if Dr. Masefield felt he could do something with it they would be very grateful. He thought the Council was right to refer it back because it did contain things open to dispute. He thought it was only laymen who imagined that child psychiatry and deficiency were one and the same thing. Children were not all defective because they were maladjusted. If Dr. Masefield could make one report of the whole thing they would get away from this criticism.

Dr. MCCOWAN asked if Dr. Masefield would be willing to receive reports from the child psychiatry people when dealing with this report.

Dr. SCOTT supported that. In connection with the editing the point of training lay psychologists should be dealt with very carefully.

Dr. LINDSAY said that no medical officer was generally long enough at an institution to become sufficiently expert at psychometry, and if they could make use of the lay psychometrist, it would save the doctor.

Dr. STEWART said they seemed to have arrived at a conclusion because they were willing to make sacrifices so that something could go to the Minister. If it was stressed that this was an Interim Report and that the members of the Association were to have the chance at a later meeting of contributing their views, he thought it would meet with agreement. After the White Paper came out would be the time to thrash out details and get out a report upon which they could agree.

The CHAIRMAN thought that was the intention. It seemed to be agreed that the matter should be left with Dr. Masefield, and it was possible that some members would like to know that he was willing to receive communications from them.

Dr. MASEFIELD was very gratified at the confidence placed in him. He felt, however, that the long discussion justified the proposal for reference back. He would like some assistance in acting as chief surgeon, and he would welcome suggestions which were practical and constructive from interested members. They would talk about it as an Interim Psychiatric Report.

It was formally agreed that Dr. Masefield should deal with the Report as suggested.

The PRESIDENT proposed a vote of thanks to Dr. Masefield for his work in connection with the Committee. (Applause.)

Dr. MASEFIELD, in acknowledgment, paid a tribute to the work which Miss Higgins had carried out in connection with the deliberations of the Committee.

ELECTION OF HONORARY AND ORDINARY MEMBERS.

The PRESIDENT proposed that the following be elected Honorary Members:

Honorary Members.

BERNARD HART, M.D., F.R.C.P.London. Member of the R.M.P.A. since 1905. Physician in Psychological Medicine, University College Hospital; Physician in Psychiatry, National Hospital, Queen Square, London; Consulting Adviser in Psychiatry to the Ministry of Health; Lecturer in Mental Diseases, University College Hospital Medical School; Lecturer at Maudsley Hospital. (Formerly Lecturer at Maghull Military Hospital; Consultant in Mental Disease

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to London Military Hospitals; Examiner in Psychiatry, University of Cambridge; Goulstonian Lecturer, Royal College of Physicians.) Publications: *Psychopathology*, *The Psychology of the Insane*, and various papers on medical and psychological subjects.

REGINALD WORTH, *O.B.E.*, M.B., B.S.Durham, M.R.C.S., L.R.C.P. Late Medical Superintendent, Springfield Mental Hospital, Tooting; Emeritus Lecturer in Psychology, Westminster Hospital; Physician and Lecturer in Psychological Medicine, Westminster Hospital.

Dr. Worth joined the Association in 1900. He was Honorary General Secretary from 1919–36, and President 1935–36. During his 17 years' work for the Association as Hon. General Secretary Dr. Worth fathered a number of progressive steps. It would take too long to enumerate all the good work he did for the Association. During his Secretaryship the Association was granted the Royal Charter, and H.R.H. The Princess Royal was pleased to accept the Honorary Certificate for Mental Nursing.

Dr. Lindsay and Dr. Bower acted as scrutineers, and as a result of the ballot Dr. Hart and Dr. Worth were declared unanimously elected Honorary Members.

After a further ballot the following were declared duly elected Members of the Association.

BIERER, JOSHUA, M.D., D.Econ.Vienna, Psychotherapist, Runwell Hospital, Wickford, Essex.
Proposed by Drs. R. Ström-Olsen, P. K. McCowan and A. Helen Boyle.

BODMAN, FRANCIS HERVEY, M.D., Ch.B., M.R.C.S., L.R.C.P., Acting Director, Bristol Child Guidance Clinic; Psychiatrist, Somerset C.C.; 2, Redland Court Road, Bristol 6.
Proposed by Drs. E. Casson, A. Lewis and R. E. Hemphill.

CRUICKSHANK, ELIZABETH HELEN MAY, M.B., Ch.B.Glas., Assistant Physician, Glasgow Royal Mental Hospital; 2, Park Circus, Glasgow.
Proposed by Drs. A. MacNiven, J. D. Uytman and W. M. McAlister.

EHRENWALD, HANS JAN, M.D.Prague, Medical Officer, Royal Western Counties Institution, Starcross, Devon.
Proposed by Drs. D. Prentice, M. L. Meade-King and D. C. Dewar.

EICKHOFF, LOUISE FRANCES WINIFRED, M.B., Ch.B.Edin., Senior Assistant Physician, Jordanburn Hospital; West House, Morningside, Edinburgh.
Proposed by Drs. H. Stalker, B. G. Daly and W. M. McAlister.

ENGLER, MARKUS, M.D.Vienna, Assistant Medical Officer, St. Lawrence's Hospital, Caterham, Surrey.
Proposed by Drs. T. Lindsay, L. Minski and J. B. Strafford Lewis.

FIRMIN, DOREEN PENELOPE, M.A.Cantab., M.B., B.Ch.Cantab., M.R.C.P.Lond., D.P.M. Lond., Deputy Medical Superintendent, St. Lawrence's Hospital, Caterham; The Firs, Coulsdon Road, Caterham, Surrey.
Proposed by Drs. T. Lindsay, G. A. Lilly and E. Cunningham Dax.

GIBSON, IMA GILMOUR, M.B., Ch.B.Glas., Assistant Physician, Glasgow Royal Mental Hospital, 1055, Great Western Road, Glasgow.
Proposed by Drs. A. MacNiven, J. D. Uytman and W. M. McAlister.

KING, GEORGE MACMILLAN, M.R.C.S.Eng., L.R.C.P.Lond., Assistant Medical Officer, Newport Mental Hospital, Caerleon, Newport, Mon.
Proposed by Drs. M. R. Mackay, N. R. Phillips and P. Drummond.

LEHMANN, HERMANN, M.D.Bale, Ph.D.Cantab., Assistant Medical Officer, Runwell Hospital, near Wickford, Essex.
Proposed by Drs. R. Ström-Olsen, M. B. Brody and W. Gordon Masefield.

MALLINSON, WILLIAM PAUL, M.A., B.M., B.Ch., M.R.C.P., Temporary Surgeon-Lieut.-Commander, R.N.V.R., Neuropsychiatric Specialist, Royal Naval Auxiliary Hospital.
Proposed by Surg.-Capt. D. Curran, Surg.-Lieut. P. D. Scott and Surg.-Lieut. M. C. Hood.

MILLIGAN, WILLIAM LIDDELL, B.Sc., M.B., Ch.B., L.R.C.P., L.R.C.S., L.R.F.P.S.G., Temporary Assistant Medical Officer, Newcastle Mental Hospital; 18, Underwood Road, Burnside, Rutherglen, Glasgow.
Proposed by Drs. J. R. Murray, R. E. Illingworth and J. R. Whitwell.

RANDELL, JOHN BULMER, B.Sc., M.B., B.Ch.Wales, P/T/Surgeon-Lieut. R.N.V.R., Holmestower, Dinas Powis, S. Wales.
Proposed by Surg.-Capt. D. Curran, Surg.-Lieut. P. D. Scott and Surg.-Lieut. M. C. Hood.

RIGGALL, ROBERT MARMADUKE, M.R.C.S., L.R.C.P.Lond., L.R.C.P.Edin., Hon. Physician, London Clinic of Psycho-Analysis; Deputy Medical Superintendent, Cefn Coed Hospital, Swansea.
Proposed by Drs. R. Worth, N. Moulson and H. Astley Cooper.

SHORVON, HYAM JOSEPH, M.R.C.S., L.R.C.P., D.A., D.P.M.Lond., Psychiatrist E.M.S.; Sutton Hospital, Sutton, Surrey.
Proposed by Drs. A. A. W. Petrie, D. Shaw and D. E. Bunbury.

STENGEL, ERWIN, M.D.Vienna, Research Fellow in Psychiatry, Univ. of Edin.; Royal Edinburgh Hospital for Mental and Nervous Disorders; 61, Morningside Park, Edinburgh 10.
Proposed by Prof. D. K. Henderson, Drs. H. Stalker and B. G. Daly.

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WEIL, PAUL LUDWIG, M.D.Tuebingen, Temporary Assistant Medical Officer, County Mental Hospital, Prestwich, Manchester.
Proposed by Drs. G. Talbot, A. McGlashan and G. H. H. Benham.

WHELEN, MAEVE, M.D., D.P.M., Medical Officer in Charge, Malaria Therapy Centre, Horton Hospital, Epsom, Surrey.
Proposed by Drs. W. D. Nicol, T. Lindsay and L. H. Wootton.

WILLIAMS, JAMES NEWTON, A.B., M.D.Virginia, F.A.C.P., Lieut.-Commander M.C., U.S.N.R., Neuropsychiatrist U.S. Naval Hospital.
Proposed by Drs. J. Watson, D. B. M. Lothian and G. M. Smith.

COMPLIMENTARY MOTIONS AND ANNOUNCEMENTS.

The PRESIDENT announced:

(*a*) That in the Honours List, 1943, the *O.B.E.* was conferred on—
E. S. LITTELJOHN, M.R.C.S., L.R.C.P., Medical Superintendent, The Manor, Epsom, Surrey.
Hon. W. S. MACLAY, M.A., M.D., M.R.C.P., D.P.M., D.T.M.&H., Medical Officer in Charge, Mill Hill Emergency Hospital, London, N.W. 7.

(*b*) The Winner of the Bronze Medal and Prize was—
Dr. C. E. H. Turner, Deputy Medical Superintendent, City Mental Hospital, Leicester.
Dr. Turner was present, and received his prize from the President amid applause.

(*c*) There was no award of the Divisional Prize this year.

"Psychogenic Amnesia: The Refusal to Remember," by Squadron-Leader D. N. PARFITT, M.D., M.R.C.P., R.A.F.V.R., and Squadron-Leader C. M. CARLYLE GALL, M.R.C.S., L.R.C.P., R.A.F.V.R. This paper was read by Squadron-Leader Parfitt (to be published later).

To conclude the proceedings the Ministry of Health Film, **"Neuropsychiatry,"** was shown.

Hon. W. S. MACLAY, in introducing the film, said that it was a record of the work carried on at Mill Hill Hospital. In wartime the problem of the anti-social effect of neuroses was very much to the fore, and psychiatry therefore had been brought into close relationship with social problems and social medicine. Because of this he made no apology for introducing the subject of rehabilitation.

However tired they might be of the word "rehabilitation" it had come to stay, and psychiatry had an important part to play in it because rehabilitation, in the fullest sense of the word, was what psychiatrists had been trying to do for their patients for years, and they had an experience which should be utilized. Surgeons, and especially orthopaedic surgeons, paid lip service to the psychological importance of rehabilitation, but it very often went no further. Halliday had pointed out the frequency of psycho-somatic illness in coal miners and he suggested two reasons for it: firstly the physical discomfort of work underground, and secondly, mechanization, which reduced men to mere automatons instead of developing skilled workers. They developed illness or became absentees for insufficient causes. It was the "browned-off" soldier who was liable to become a neurotic, and it was the tired civilian who gave way to panic. Halliday recognized the need of a community in which the individual felt he had a part to play and the responsibility of doing so. Beveridge, in his Report, said the individual should recognize the duty of being well, but often this was not so. Many felt they were ill through no fault of their own, and it was up to someone else to make them well. In a recent article rehabilitation was defined as restoration, and the Tomlinson Report stressed that restoration to physical health with too little regard to the need for incentives to make a man want to get well and want to use the various agencies suggested in the Report so that he could become a well-adjusted member of the community. He did not think the psychiatric point of view was sufficiently stressed, nevertheless doctors who had concerned themselves with restoration were adopting a more social attitude.

The necessity of winning the war made that spirit, and when peace came he believed that the changes in the social structure, the needs of the community, would equally have to be borne in mind. The new rehabilitation programmes were concerned with restoration not only of the part concerned, but with the individual as a physical whole, and it was recognized that special jobs for men who had lost a limb were necessary.

Psychiatrists were concerned with people who might be physically whole, but who were maladjusted to the community in which they lived, and in that maladjustment showed a variety of symptoms. A considerable number of patients who might be expected to be made well by the rehabilitation programme of medicine and surgery would be maladjusted, and would not recover satisfactorily because of neurotic mechanisms. These neurotic mechanisms could be dealt with by suitable means, and some of the methods adopted were illustrated in the film. They included individual psychotherapy, group treatment, occupation courses, and the general morale of the hospital was built up by every member of the staff, especially the nurses. Social workers were used, and the provision of incentives towards social integration and away from self concentration was a large part of the treatment for return to the Army or through the Ministry of Labour schemes to civil life.

Mild neurotic difficulties could be dealt with by common sense used with knowledge and understanding of the difficulties, and such common-sense considerations would be applicable to

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every patient to a greater or lesser extent; without them the results would be that much less effective. More severe disabilities required the special knowledge of psychiatrists. Psychiatrists did not wish to take over the running of all the rehabilitation centres, but their experience should be used in planning the general organization of such centres. That was where some of them failed and psychiatrists should be available, as were other specialists, to advise in individual difficult cases.

What he had said might amount merely to the expression of psychiatric first principles, but the ends mentioned had not been easy to achieve, and he would not claim that they had been achieved. The film showed what they were trying to do, not how it ought to be done. It was intended for non-psychiatric medical audiences rather than for psychiatrists, and it was hoped that it would give some idea of what went on in a neuroses centre and would remove some misconceptions. As the average length of stay was six weeks, it would be appreciated that some of the more profound disturbances could not be rectified—for example, a severe mechanical obsessional state; and the point of view, taken sometimes, that if they got their results in such a short time why did psychiatric treatment take so long and why was it so expensive before the war, was not fair. They were greatly helped by pre-selection of suitable cases, and many cases of invalidism were easy and straightforward to deal with. The fundamental problem had been to apply psychiatric principles to large numbers of patients imposed by circumstances of war. The annual admission-rate was the same as for the whole of the L.C.C. hospitals added together. The problem had also been to adapt psychiatric methods for use in what were necessarily short periods of treatment, using a restricted staff, some of whom had only had a restricted training. Now that the film was finished there were many parts he would like to eradicate or film differently, but that would have been the case in any event.

After the film had been shown, Dr. PARFITT said that it was a description of the various facilities in a mental hospital applied to mental neuroses. He commented on the reply of a sister to a patient that the hospital was not a mental hospital.

Dr. MACLAY said he agreed that the comment was unfortunate, but the sisters dealt with the patients as seemed best, and this man's main fear was that he should be sent to a mental hospital. If a patient asked him whether it was a mental hospital he replied that it was and then explained. He had asked that this scene should be changed, the Ministry had refused to do so, but if it gave a bad impression he would ask again.

Dr. KIMBER thought it would be best to have it changed.

Dr. T. P. REES said that although it was a picture of what was done in mental hospitals, Dr. Maclay should be congratulated on his magnificent work. He had started from scratch and had put in a very great deal of hard work. It was one of the most enjoyable pictures he had seen for a long time, and their thanks were due to Dr. Maclay and his staff for producing the film.

Asked if the film would be available for showing in the mental hospitals throughout the country, Mr. MACLAY replied that it was under the control of the Ministry of Information, and anyone who wished to have it could write to the Ministry at Malet Street, London, W.C. 1.

VOTE OF THANKS.

Lt.-Col. RUSSELL proposed a very hearty vote of thanks to the speakers who had entertained and instructed the meeting. He personally was delighted with the general conclusions at which Squadron-Leader Parfitt had arrived because they corresponded with his own feelings. He felt they owed an apology to Dr. Maclay, but he would understand that that audience had a pronounced sensitiveness with regard to mental hospitals. Every one of them had a reaction when it was suggested that it was a bad thing to go to a mental hospital!

The vote of thanks was accorded by hearty applause, and the proceedings terminated.

NORTHERN AND MIDLAND DIVISION.

THE Spring Meeting of the Division was held, by the courtesy of Dr. Geoffrey Talbot, at the County Mental Hospital, Prestwich, on Friday, April 30, 1943.

Present: Dr. Talbot, in the Chair, Drs. Bamford, Benham, Bruce, Brunton, Cates, Clarke, Cormac, Crowe, Erskine, Fairweather, Finkleman, Fox, Grant, Harris, Hart, Hull, Lowy, McGlashan, McLaren, N. F. Mackenzie, D. Macmillan, Power, Lt.-Col. J. I. Russell, Drs. Starkey, Stein, Thorpe, Torrance, Williamson, and two visitors.

Dr. TALBOT, who presided, referred to the unfortunate illness of Dr. E. F. Reeve, Divisional Chairman, and the Secretary was instructed to convey to Dr. Reeve the members' sympathy and good wishes for his recovery.

The minutes of the previous meeting were read and confirmed.

The following, after ballot, were duly elected to ordinary membership of the Association:

GERARD CAPLAN, M.B., Ch.B., D.P.M., R.C.S., Assistant Medical Officer, Winson Green Mental Hospital, Birmingham, at present on service in R.A.F.; 6, Ramillies Avenue, Cheadle Hulme, Cheshire.

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