

Online archive 25b (i)

Standing committees and sections

The Association comprised the officers and from an early stage a Council. They also had special committees of Council charged with separate responsibilities. Some of these became standing committees, some were closed when they had accomplished their tasks. Some of the committees dealt with the subspecialties within psychiatry and these metamorphosed from committee to group to section to faculty. Two sections which did not become faculties: (1) Rehabilitation and Social Psychiatry, (2) Liaison Psychiatry, are dealt with in this online archive.

STANDING COMMITTEES

Standing committees have been an essential part of the administrative structure of the Association and of the College, but the system of committees meeting regularly with responsibility for particular areas of work developed only towards the end of the 19th century. For its first fifty years the work of the Medico-Psychological Association was carried out by the Officers and Council, who reported to Annual and Council meetings. The standing committee best represented in the College archives was the Education (originally called the Educational) Committee. An Education Committee or Board of Education was established at the 1892 Annual Meeting; membership was open to all MPA members who were teachers of psychological medicine in universities or medical schools. The committee was not large. Minutes from 1893 to 1971 are in the archives. With the minutes are question papers and regulations for the certificates and diplomas in psychological medicine administered by the MPA and RMPA for the nursing examinations it ran until the 1950s. The archives also include minutes of Education Committee sub-committees from the 1950s to 1970s, namely the Clinical Tutors, Films, General Purposes and Mental Nursing Sub-committees. The Parliamentary Committee developed from the Lunacy Legislation Watch Committee of 1877 so can be considered the oldest standing committee. The archives contain a

long series of its minutes although these do not begin until 1906. Despite the title, the main work of this Committee in the early part of this century concerned asylum officers' pensions and working conditions.

A Library Committee was first suggested in 1877, the development of a circulating library having been suggested as a suitable use for the MPA's surplus funds. A Standing Committee was established in 1896 after the MPA received a large bequest of books from Dr Daniel Hack Tuke's widow. The only record of this Committee is a minute book from 1904-51 by which time there was no suggestion of 'surplus funds' being available and in which the topics under discussion were library accommodation and security, and the late return or disappearance of books. The Association also had a Standing Papers and Discussions Committee from 1946 and a Public Relations Committee, established in 1957 'to study the education of the Public and Press in Mental Health Matters' minutes of which are in the archives. A Standing Research and Clinical Committee was established in 1927 although there had been a Research Committee in 1914. Neither the MPA nor RMPA had a standing editorial or finance committee. Both the Editor and Treasurer reported to Council and annual meetings and the Editor had the help of assistant editors, an editorial board and occasional special committees, including the Journal Delays Committee of 1897. There are no known MPA or RMPA editorial or financial records for the Journal.

Structural reforms within the College in 1995 led to the future of the Social Psychiatry and Liaison Sections becoming uncertain. There appeared to be no role for the Social Psychiatry Section as General Psychiatry was to embrace community issues, but

rehabilitation seemed to deserve more than special interest status as it had its own allocation of Senior Registrars and a discrete training programme. Similar arguments were deployed for Liaison Psychiatry, which resulted in both sub-specialties being made a Section within the new structure.

Sections at the end of the 20th century

1. Section of Rehabilitation and Social Psychiatry Section

Rehabilitation psychiatry has a long history within the R.M.P.A. and later the College. Its practitioners prepared patients for life outside an institution and ensured that good social conditions, including the application of insights into interpersonal relationships within the family, informed the practice of the rehabilitation team. These practitioners found their home within the Social Psychiatry Section of the College. In 1981 the College issued a pamphlet *Rehabilitation in the Eighties* which stimulated considerable discussion both within and without the College. There were many who felt that the application of psychosocial principles to persons with psychiatric disability had more to offer than mere discharge from hospital, as it could offer a healthier and more enjoyable life. In 1982 a small informal group, led by Professor John Wing met to delineate the principles of Rehabilitation psychiatry and the role of the rehabilitation psychiatrist. Their paper was produced at a fringe meeting of the AGM that year. The audience exceeded 80 members who not only endorsed the paper but asked that the College better recognise the work of its members working within rehabilitation. Meetings of rehabilitation psychiatrists continued at the College to work on the issues of education, research, and liaison with other groups both within and outside the College. The Social Psychiatry Section hosted this group, which, after considerable

discussion within the section, was called the Rehabilitation Forum. This began to produce documents that demonstrated both the range of rehabilitation, the educational requirements for the sub-specialty, as well as a survey of manpower and resources. The Social Psychiatry Section had become focussed upon Community Psychiatry and Rehabilitation. There were debates on the nature of each of these contrasting interests. It was argued that community psychiatry was good general psychiatry carried out within a community setting; while on the other hand it was held that rehabilitation belonged to the past as so many of the disabilities arose from long-term institutional care. An argument was also made that rehabilitation deserved more than special interest status as it had its own allocation of Senior Registrars and a discrete training programme. Similar arguments were deployed by Liaison Psychiatry, which resulted in both sub-specialties being made Sections within the new structure. Rehabilitation psychiatrists today acknowledge their debt to the principles of social theory and the Rehabilitation and Social Psychiatry Section started in 1996.

2. Section of Liaison Psychiatry

The closure of asylums and the move of their patients into the community focussed psychiatric resources on chronic psychotic illnesses, neglecting the psychological problems of general hospital patients. Medical and surgical patients have a high prevalence of psychiatric disorder which can be effectively helped with both psychological or pharmacological treatments. Until the 1970s specific liaison psychiatry services were virtually unknown in Britain. Informal discussions between interested clinicians took place in the early 1980s and a consensus emerged that liaison

psychiatry would be served best by establishing a group within the Royal College. A letter to the *Bulletin* drew a response which indicated that there was considerable enthusiasm for establishing a national group to provide a forum for clinical, research and teaching interests in the field of consultation and liaison psychiatry. The College then recognised liaison psychiatry as a specialist interest group. At this time there was substantial clinical and academic activity but insufficient time to carry out all aspects of this type of work satisfactorily. Services appeared to have developed haphazardly and few districts had given priority to developing liaison psychiatry. Most services were provided by general psychiatrists, some of whom had a special interest in liaison psychiatry. Richard Mayou, who had been the prime mover in establishing the group, was elected Chairman and served in this capacity until 1989.

Increased recognition and status of liaison psychiatry led to the creation of a growing number of consultant posts and a handful of university chairs. By 1996 there were 86 consultants in England, Scotland and Wales who carried out specific liaison work, 43 of whom had either full-time or half-time posts in liaison psychiatry. Sixteen new posts had been created during the previous two years but staffing levels still fell below the College's recommended guidelines of 0.4 full-time equivalent posts per 100 000 population. Many large general hospitals now have a distinct liaison psychiatry service and these developments have enabled more trainees to acquire relevant experience. The College recognised this by changing the group to a Section in 1997. This Section has held joint meetings with other organisations, involving other medical specialists and non-medical professionals who treat similar patients. Meetings were held with the British Diabetic Association and biennial meetings with the Society for Psychosomatic

Research. Joint meetings have also been held with liaison psychiatrists from Holland, Portugal and the Nordic countries. There has also been the development of links with other Royal Colleges. Two joint conferences with the Royal College of Physicians of London were held on medically unexplained symptoms and psychiatric aspects of physical disease. These facilitated the establishment of a joint working party on the psychological care of medical patients. This report made recommendations on the provision of a liaison service in each general hospital and on the training of medical and other staff in recognising and managing psychological problems in medical patients.

A joint working party with the Royal College of Surgeons published a similar report on the psychological care of surgical patients. This underlined the importance of training clinicians to recognise psychological problems such as alcoholism in surgical practice. Surgical teams working in areas of high psychiatric morbidity, for example breast care, pain control, cancer and cosmetic surgery, should identify staff members who could be trained in the delivery of effective psychological care. For help with the management of problem cases every surgical team should have rapid access to a consultant led liaison psychiatry team. A joint working party with the British Association for Accident and Emergency Medicine (Royal College of Psychiatrists, 1996) made recommendations on the provision of safe and secure assessment facilities in all accident and emergency departments. A further report was prepared with the Royal College of Obstetricians and Gynaecologists. Members of the Section have made major contributions to Council Reports on the management of chronic fatigue and deliberate self-harm and to the College Seminars Series. There have also been

publications on the planning, organisation and management of services. With a current membership in excess of 1500 the Liaison Psychiatry Section has met a need of College members. It has helped develop criteria for training and encouraged the establishment of liaison services with specific consultant appointments. It is the only national body to represent liaison psychiatry in the UK. The separation of psychiatry from the rest of medicine, embodied in the establishment of separate community mental health trusts, increases the need for a psychiatric service dedicated to the psychological needs of medical and surgical patients in general hospitals.