public hospitals. On completion of their general training these nurses have returned to our service where their double qualification renders them particularly well qualified to hold the higher nursing positions in the Department.

In addition to our own nurses who return to us in this way we have recently engaged a number of other general trained nurses who are anxious to acquire a knowledge of mental nursing, and to whom we make a concession of one year in the period of instruction.

In all we have forty-eight general trained nurses on our staffs, and the liaison thus established between the mental hospital and the general hospital cannot fail to have a result beneficial to both.

This year we have instituted a medallion for proficiency in mental nursing which those who pass the final examination are entitled to wear, and so far 288 nurses and attendants have availed themselves of this privilege.

The Psychological Clinics.

Since the passing of the Mental Defectives Amendment Act in 1928 two psychological clinics have been established by the Department—one at the Head Office in Wellington, conducted by Dr. John Russell, and the other in Auckland, under Dr. Kathleen Todd.

During the year 571 new cases have been seen at the clinics, and the following table shows the sources from which they were referred :—

	Wellington.	Auckland.
Department of Education	35	98
Department of Education (Child Welfare Branch)	132	37
Department of Health (School Hygiene Division)	42	28
Magistrates' and Children's Courts	19	11
Parents, guardians, medical practitioners, societies, and orphanages	128	41
	356	215
Total	571	

The number of new cases, although impressive, does not by any means indicate the extent or nature of the work being carried on by the clinics. From the outset we have endeavoured to avoid the tendency observed in other countries for these clinics to become mere machines for the collection and tabulation of symptoms, and our aim has been that they should deal in an eminently practical way with each case presented. To carry out this ideal our investigations have been concerned not merely with the mentality of our patients, but have embraced also all those physical, economic, and socialogical conditions which make up his environment and which have to be intelligently, as well as sympathetically, appreciated before readjustment is possible.

The clinics have now been established over three years, and Dr. Russell in the following report gives his views as to the directions in which this aspect of the work is likely to be of most value :—

"There is little difficulty in deciding the treatment and necessary training or care of children of feeble-minded or lower-grade mentality once a definite diagnosis is made. The ability of the parents to co-operate in the training of each child is a major factor in deciding whether a child will be most benefited by remaining with the parents or being placed in a suitable home. The educability of the individual child determines whether the child is suitable for special training in a special school or class or at Templeton Farm.

"The most difficult problem very often is the child who is on the border-line (80–90 per cent. normal intelligence), coming as he does between the normal and the definitely mentally deficient. The difficulty generally arises because too much is expected of such a child, who may manage to pass his standards until reaching the Fourth or Fifth, and then fails. Such children are sometimes placed in a special manual class at the technical school, which in many cases proves to be most successful. In others, however, inability to grasp any form of higher education leads to a complete loss of interest, and the child, seeking an outlet in other directions, may begin to play truant, indulge in petty thieving, or indulge in other actions of an anti-social nature. If properly handled and the way opened out for employment in a channel suitable to the child's mentality, complete readjustment takes place and happiness is regained.

"When the clinics were first started most of the children examined were mentally deficient or border-line cases. As time has gone on it has been found that a gradually-increasing number of normal children have been brought for advice because of behaviour problems. It has also been found that an increasing number of children have been referred by medical practitioners and brought by the parents themselves, as apart from cases referred by various social-service organizations.

"As regards normal children who have been referred or brought for advice because of varying abnormalities in their behaviour, it has been found that they very largely fall into one or other of the following groups :—

"(1) Children with positive behaviour characteristics—*i.e.*, the aggressive type expressing themselves in various forms of abnormal behaviour, such as stealing, lying, temper tantrums, fighting, cruelty, and sex difficulties at home or at school.

"(2) Children with negative behaviour characteristics—*i.e.*, the timid, self-effacing type, expressing themselves by abnormal timidity, seclusiveness, selfishness, emotional disturbances, fears, excessive crying, insomnia, and night terrors.

"(3) Children with habit disorders : Very often children brought because of these habit disorders are found to belong to one or other of the above classes—*e.g.*, stammering and stealing (often found in association) or stammering and fears ; Enuresis (bed-wetting), associated with stealing or lying, and very often with fears and timidity ; eating and sleeping difficulties and habit spasms.

"(4) Abnormal behaviour in conjunction with physical diseases : Choreas, post-encephalitic states, polio-encephalitis, malnutrition, fatigue, &c.