THE
BRITISH JOURNAL OF PSYCHIATRY
(THE JOURNAL OF MENTAL SCIENCE)
[*Published by Authority of the Royal Medico-Psychological Association*]
SUPPLEMENT, AUGUST 1966

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

SPRING QUARTERLY MEETING

THE SPRING QUARTERLY MEETING was held on 3 and 4 May, 1966, at Mapperley Hospital, Nottingham, under the Presidency of Professor T. Ferguson Rodger and by invitation of the Hospital Management Committee and Dr. D. Macmillan, Physician Superintendent.

Minutes

The Minutes of the Quarterly Meeting held in London in February, 1966, having been published in the *Journal*, were approved.

Obituary

The President announced with regret the death of the following members:

BIGGAR, JEAN, Psychiatrist, Davidson Clinic, Edinburgh. An Ordinary Member since 1947.

BUTTLE, ROBERT LESLIE, Deputy Medical Superintendent, Fulbourn Hospital, Cambridge. An Ordinary Member since 1940.

MACKENZIE, MURDO, formerly Physician in Psychological Medicine, St. John's Hospital, Lewisham. An Ordinary Member since 1963.

PARKER, TERENCE GRANTHAM, Psychiatric Registrar, Moston and Deva Hospitals. An Ordinary Member since 1961.

PORCHER, HENRY IESTYN HUGH, Assistant Psychiatrist, Morgannwg Hospital, Bridgend. An Ordinary Member since 1951.

Election of Ordinary Members

The following were unanimously elected to Ordinary Membership:

AHSANUDDIN, KHAJA M., B.Sc., M.B., B.S., Senior Staff Psychiatrist, Taunton State Hospital, Taunton, Mass., U.S.A.
Proposed by Drs. B. McCaffrey, D. J. Bradley, K. R. Walsh.

BROWNE, NOEL CHRISTOPHER, B.A., M.D., Assistant Medical Officer, St. Brendan's Hospital, Dublin.
Proposed by Drs. D. J. Bradley, H. J. Burke, H. E. O'Sullivan.

CARROLL, ANTHONY GERARD, M.B., B.Ch., B.A.O., Registrar, St. John of God Hospital, Stillorgan, Co. Dublin.
Proposed by Drs. S. D. McGrath, P. D. McCarthy, P. Tubridy.

DAS GUPTA, SATRUJIT SANKAR, M.B., B.S., D.P.M., Private Practitioner, 78 Ballygunge Gardens, Calcutta, 19, India.
Proposed by Drs. R. B. Davis, Ajita Chakraborty, P. K. Roy.

DIJI, AUGUSTINE, B.Sc., M.B., B.Ch., B.A.O., Registrar, Windsor Unit, Belfast City Hospital, Belfast.
Proposed by Drs. A. S. Clenaghan, S. J. Knox, J. W. G. Nixon.

DUFFY, JAMES L., M.B., Ch.B., Registrar, Stobhill General Hospital, Glasgow.
Proposed by Drs. Hunter Gillies, A. F. McLean, A. H. Frame.

FORD, KEVIN RAYMOND, M.R.C.S., L.R.C.P., D.P.M., Psychiatrist, Winnipeg Clinic, Manitoba, Canada.
Proposed by Drs. J. M. Dougan, J. D. Lucy, O. J. Slowik.

GALLAGHER, HUGH KEVIN, M.B., Ch.B., Registrar, Stobhill General Hospital, Glasgow.
Proposed by Drs. Hunter Gillies, G. P. McGovern, A. F. McLean.

https://doi.org/10.1192/S0007125066307792 Published online by Cambridge University Press

GOKCEN, MEHMET IHAMI, M.B., Staff Psychiatrist, Mont Providence Hospital, Montreal, Canada.
Proposed by Drs. D. J. McClure, L. G. Lohrenz, W. D. Henry.

GREEN, BETTY FLORENCE, M.B., B.S., Medical Officer, Child Guidance Clinic, 590 Newcastle Street, Perth, Western Australia.
Proposed by Drs. Susanna Isaacs, Beryl Margolis, R. Hunter.

JORDAN, BRIAN, M.B., Ch.B., Registrar, Bangour Village Hospital, Broxburn, West Lothian.
Proposed by Drs. A. K. M. McCrae, F. G. Lassalle, D. E. H. Beattie.

KHAN, ILTAF AHMAD, M.B., B.S., Graded Specialist in Psychiatry, Military Hospital, Rawalpindi, Pakistan.
Proposed by Drs. M. Shuaib, S. M. A. Habib, M. Ashraf.

NEWMAN, RITA ROSLYN, B.A., M.D., Psychiatrist, St. Barnabas Hospital, Livingston, New Jersey. U.S.A.
Proposed by Professor E. Stengel, Drs. N. Kessel, J. Hoenig.

SANDHU, SURINDER SINGH, M.B., B.S., D.P.M., Research Fellow, Indian Council of Medical Research; Hospital for Mental Diseases, Kanke, Ranchi-6, Bihar, India.
Proposed by Drs. K. Bhaskaran, L. P. Varma, R. B. Davis.

WHITTY, RICHARD JOSEPH, L.R.C.P. & S.I., L.M., D.C.H., Research Fellow, Department of Social Medicine, Trinity College, Dublin.
Proposed by Drs. Mary Sullivan, A. Walk, Professor T. Ferguson Rodger.

Election of Associate Members

The following candidates for Associate Membership, having previously been approved by Council, were elected:

PARBOOSINGH, R. C., A.B.(USA), B.A., Dip.Psych., Senior Clinical Psychologist, Springfield Hospital, London, S.W.17.
Proposed by Drs. F. Post, M. Markowe, A. B. Goorney.

VALLANCE, R. C., B.Sc., Ed.B., Principal Psychologist, Scottish Education Department, Approved Schools Branch.
Proposed by Drs. K. R. H. Wardrop, J. B. McWhinnie, M. M. Whittet.

Report of Council Proceedings

The General Secretary (Dr. A. B. Monro) read the following Report:

Council met yesterday afternoon and considered the report of the Special Committee on the Petition. This Committee reported that the draft amended Bye-laws were being considered by the Privy Council and that the draft Supplemental Charter relating to the amendments in the Bye-laws was in the process of being drafted by Counsel.

Dr. Skottowe gave an account of the recent exchanges between the R.M.P.A. and the Royal College of Physicians of London. The President of the R.M.P.A., in October, had written to the President of the Royal College asking for the support of the College in the R.M.P.A.'s aspirations to become "the Royal College of Psychiatrists". Following the receipt of this letter the matter had been carefully considered by the Psychological Medicine Committee of the Royal College and the report of this Committee had been presented to Comitia, the governing body of the College, last Thursday. A letter had now been received from the Registrar of the Royal College indicating that this report had been approved. It was understood that the approval by Comitia was without a dissentient vote. The gist of the report was a setting out of the case of the R.M.P.A. to aspire to become a Royal College, and the continued interest of the Royal College of Physicians in the growth of psychiatry. The Report of the Psychological Medicine Committee of the Royal College of Physicians was, of course, a confidential document which could not be published either in whole or in part. Those who had seen it, however, were completely agreed that it fully supported the aspirations of the R.M.P.A. The decision of Comitia meant that this was now the official policy of the Royal College of Physicians.

An informal communication from our Privy Council agent indicated that this report could only be considered as clear support for the R.M.P.A.'s aspirations. It was decided that a further meeting of the Petition Committee should be held in the near future, possibly in conjunction with our legal advisers, in order to determine the next step to be taken.

Council next discussed the setting up of a Special Committee which would become the Court of Electors on the inception date. It was agreed that by employing this method much preliminary work could be done during the time that the Privy Council were considering the new bye-laws. It was agreed that before the July Meeting all members of Council should be circulated with a view to appointing the Special Committee by a postal ballot of Council members.

Council appointed Dr. Linford Rees as the official delegate of the Association to the World Psychiatric Association Congress to be held in Madrid in September, and fully endorsed the nomination of Dr. Denis Leigh to be Secretary and Dr. Linford Rees to be Treasurer of the W.P.A.

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Following the Treasurer's report it was decided to keep under constant review the expenditure of the Association and to continue considering the work of our technical advisers with a view to getting the maximum efficiency.

The Editor-in-Chief was arranging for the *Journal* to be published as well as printed by Headley Brothers. This should result in some saving. Equally, the position as regards advertising revenue had improved sharply, and a total saving of several thousand pounds might be possible.

Council considered the report of the Parliamentary Commiteee on Therapeutic Abortion. While approving parts of the report, they decided that other parts required re-casting and suggested that the Special Committee should meet again, with the addition of Dr. Howells and Dr. Cook, under the Chairmanship of the President. The Committee was authorized to amend the draft and submit it to the proper quarters, including the Press. The expanded memorandum on Drug Addiction was approved. A statement on the vexed question of driving licences will be circulated to all members before the July Meeting.

Following the receipt from the B.M.A. of a letter and a memorandum about the allocation of Distinction Awards, Council agreed to write strongly supporting the efforts of the Psychological Medicine Committee of the B.M.A. to secure a higher allocation of awards for psychiatry. It was felt that common cause should be made with other specialties suffering from a low level of allocation.

Council agreed that psychiatry should be represented on the Working Party on the Standardization of Hospital Medical Records by Drs. Pilkington, Spillane and Roberts, and it was agreed that an approach should be made suggesting to the Ministry that there should also be an expert on epidemiology, either Professor Rawnsley or Dr. Sainsbury.

It was agreed that Drs. Warren, Clouston and Holman should represent the Association on a Joint Committee with the Society of Medical Officers of Health on the subject of Schools for Maladjusted Children.

A proposal by the Psychotherapy and Social Psychiatry Section to the effect that Quarterly Meetings should always be held on Fridays and Saturdays was considered. Some sympathy for this view was expressed and it was decided to consider the matter further and place the issue on the Agenda for the July meeting of Council.

Council considered a proposal by the Australian and New Zealand College of Psychiatrists to hold a joint meeting with them in London on 17 September, 1966. It was decided that the President, General Secretary and representatives of the Papers and Discussions Committee should try to make satisfactory arrangements for the meeting in the time available.

PAPERS

The following papers were read:

Symposium on Forensic Psychiatry

MENTAL ABNORMALITIES AND RECIDIVISM IN CRIMINALS
Dr. T. C. N. Gibbens

AN EVALUATION OF FACTORS POTENTIATING JUVENILE DELINQUENCY
Dr. D. J. West

THE OPERATION OF PART V OF THE MENTAL HEALTH ACT, 1959
Dr. Nigel Walker

RESEARCH PROSPECTS IN FORENSIC PSYCHIATRY
Dr. R. D. Brittain

SEMINARS

The following Seminars were presented on Tuesday 3 May, 1966:

Problems of a Geriatric Mental Health Service, by Dr. DUNCAN MACMILLAN.

Hysteria, by Professor W. ABSE.

The Adult Adjustment of Foundling Home Children Compared to Foster Home Children, by Dr. L. HESTON.

Some Views on the Treatment of Alcoholism, by Dr. ALFRED MINTO.

FILM SHOW

The following films were shown:

Child Draw Nearer.

The Disturbed Subnormal Child—A Cinerecording of Therapeutic Response.

Stranger in His Own Country.

HOSPITALITY

Members and their wives were guests of the Hospital Management Committee to a most enjoyable informal Dinner on Tuesday, 3 May.

SECTION MEETINGS

The *Child Psychiatry Section* met at St. Ann's Unit. Drs. Portia Holman, G. M. J. Nicholl, J. D. Orme, T. A. Ratcliffe, D. J. Salfield, F. G. Thorpe and A. C. Woodmansey took part in a Brains Trust on the "IMPLICATIONS OF THE WHITE PAPER ON THE FAMILY, THE CHILD AND THE YOUNG OFFENDER".

https://doi.org/10.1192/S0007125066307792 Published online by Cambridge University Press

At the meeting of the *Research and Clinical* Section, the following papers were read:

The Evolving Comprehensive Mental Hospital and its Services

By Dr. Duncan Macmillan

The term "Comprehensive Mental Hospital" is the official designation applied to mental hospitals in order to differentiate them from the psychiatric units attached to general hospitals.

The present policy of the Ministry of Health involves two concurrent processes, one of which may be called the "run-down" of those comprehensive mental hospitals which have been selected for retention in the planning programme, while the other may be termed the "build-up" of the psychiatric unit services.

An obvious question is whether it is better to "run-down" or to "build-up".

I should like to put forward the argument that, where there is a choice, it is better to "run-down" than to "build-up". If care is taken in pruning a service which has previously been over-elaborated in certain directions, one is unlikely to dispense with any function which has been found to be of value to the patient. The process of retention and modification of an existing service is easy, but the build-up of a new equivalent service is a much more difficult proposition. Also, one does not know the extent of all the long and short-term needs of an area until services have been provided and have been in operation for some time.

Mapperley Hospital is responsible for the mental health services of a population of 408,000.

In-Patient Services

Perhaps the most striking fact statistically about the in-patient services has been the reduction in the number of beds from over 1,300 in 1948 to the present figure of under 700. This total includes all the beds in the main hospital, three admission units situated a mile away, two hostels, the addiction unit, and the psycho-geriatric hospital three miles away.

The initial objective was to provide a sufficient number of admission units for proper classification, and the conversion of the previous long-stay wards into day-hospitals, rehabilitation wards, and hostels.

The attainment of these objectives has imposed a strain at times on the services of certain sections of the hospital. Sometimes the resources of the admission units have had a heavy load.

During this process we have learned many lessons; we have seen how very often in-patient care can be replaced by out-patient treatment and day treatment without detriment to the patient. No service considered to be of benefit to the patients has had to be discontinued.

Admission Units

There are now eight *admission units* with a total number of 197 beds. Each discharges its patients directly back to the community, and has its own after-care programme.

Five wards are gradually developing *active rehabilitation services*. They house 168 patients. They are not yet functioning fully as therapeutic units, but progress has been made with the therapeutic community approach. A Hospital Employment Bureau Committee organizes all the arrangements for the occupation of in-patients, and also of those day patients who are not in the industrial therapy organization.

Two *hostels* are administered and staffed by the hospital, one for schizophrenic male patients and one for female patients. Two female wards are run on hostel lines. Altogether this gives a total of 96 hostel beds.

The *psycho-geriatric hospital* is situated in the grounds of the City Hospital, and has three female and two male ordinary admission wards each of 20 beds.

Another female ward of 20 beds admits patients for short-term prophylaxis; another is to be used for prophylaxis as a mixed ward, and a third as an assessment unit for the joint use of the geriatrician, the local authority welfare services, and ourselves.

There are in the main mental hospital three female geriatric admission wards with a total of 72 beds. The total number of beds allocated for geriatric psychiatry is 234.

The *children's in-patient* unit has 20 beds, and the *addiction unit* has at present 9 beds.

In the near future the *admission unit beds* are to be increased to 234, i.e. 0·57 beds per 1,000 of population served.

It is planned to reduce the number of beds in the *rehabilitation wards* to 98 in five units, one of which will be gradually converted to day treatment. This will then give 0·24 beds per 1,000 for active rehabilitation.

An *adolescent unit* has been agreed and planned for 10 beds. There are also proposals for a "mother and baby unit" of 8 beds, and for the first stage of a Regional purpose-built addiction unit.

For a population of 408,000 there will be a total provision of 1·7 beds per 1,000.

Rehabilitation, Resettlement and Community Services may be considered under the three headings of (1) out-patient services, (2) domiciliary community

https://doi.org/10.1192/S0007125066307792 Published online by Cambridge University Press

services, and (3) day hospital services with associated (*a*) economic rehabilitation and (*b*) social resettlement. For day hospital treatment during 1965 there were 71,932 attendances. The day hospital units are 8 in number, four of which, two geriatric and two non-geriatric, occupy four former in-patient wards, and two are day industrial therapy units, of which one is a new purpose-built unit with 100 places and the other is in the female hostel. These eight units provide over 350 day places with over 400 day attenders.

A separate geriatric day centre administered by the local health authority, Nuffield House, provides also a most useful service of prophylactic day-care for the elderly.

Our experience has been that the day treatment of the long-term psychotic patient in the community requires reinforcing either by economic rehabilitation or by social resettlement, or by both.

The new industrial therapy day unit has a section of an outside factory working in it, and is a self-contained unit with its own canteen.

The second industrial therapy day unit, designed solely for female attenders, is situated in the female hostel, and has a day nursery for their children.

A sheltered workshop, adjacent to the industrial therapy unit, is planned, and awaits approval of the Ministries of Health and Labour.

Another group of day patients are unable through greater psychiatric disability to attain an economic working level, but they are sufficiently well to appreciate living in the community and to attend for therapeutic group activities. They require help with their problems of accommodation and social resettlement, and for this a small Department of Social Resettlement has been established.

Entry to the hostels or hostel wards of the hospital is the first step in the resettlement of the patient. We find that what may be called rehabilitative lodging houses are required in the community. In these the patients are helped by the social workers or mental welfare officers until they are able to stand on their own feet. We need also what may be termed "supportive hostels" for the long-term care in the community of those patients who are unlikely to become self-supporting.

The Manchester Plan for Psychiatric Services

By Dr. Stanley Smith

One of the most important aspects of the Manchester Regional Plan is development of General Hospital Psychiatric Units. There are three types: the "comprehensive" such as Oldham, Blackburn, Burnley and Bolton, which take in a whole range of patients and cater for well over 95 per cent. of their problems, and require little or no support from a near-by mental hospital. The second type of unit is smaller, ranging from 30 to 60 beds and is designed to be supported and very closely integrated with a nearby mental hospital. There are very few of these at the moment in the Manchester Region. The third type is that usually found in the teaching hospital areas: these units are small and very selective, e.g. the 18-bedded Unit in Gaskell House at Manchester Royal Infirmary.

As far back as 1948 (2) the Manchester Regional Hospital Board emphasized the value of psychiatric units in General Hospitals and it was planned that psychiatrists should be appointed primarily to these hospitals, with only one or two sessions per week at a nearby Mental Hospital. This was based on the proposition that "psychiatry has come to be recognized in this region as an essential general hospital service". Most of the Units are attached to old Municipal Hospitals which, of course, with an infusion of National Health Service money, have been up-graded so that each is in fact today a reasonably modern general hospital. Each unit serves a population ranging from about 120 to 260 or more thousand. The largest "comprehensive" Unit has 252 beds; the smallest about 100.

Practical experience has suggested that a psychiatric unit of 100-120 beds can be expected to serve a population of a quarter of a million people, providing that adequate geriatric accommodation is at hand. Because of their small size, emphasis on out-patient work and ease of access, they have proved very successful in co-operating with Local Authorities, and with the growth of community services co-operation has become even more important. The number of annual admissions to the Units varies considerably, from 200 to 340 per annum or even more.

How many patients are transferred to local mental hospitals? In 1958, from two areas, Burnley and Oldham, only 32 patients were so admitted. The picture for other units at the time was less favourable than this, but now a growing number of such departments show similar statistics.

Leyberg (1959)(5), a consultant in charge of such a Unit, expressed the fear that "As the number of chronic patients gradually increases a small unit may soon become unable to admit new cases". Yet, in 1964, his own Unit was dealing with well over 95 per cent of the patients in its catchment area. This picture seems inconsistent with the idea of a growing number of long-stay patients blocking beds. In fact, recent figures show that the proportion of recent admissions from the Manchester area likely to become long-stay is falling. For example, at the end of 1958

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about 8·8 per cent. of patients admitted in 1956 were still in hospital, but in 1965 the number in hospitals was only 4·2 of those admitted in 1963. Most of the psychiatrists using these Units would now maintain that they do not need any mental hospital facilities at all.

The Effect on Mental Hospitals

It is perfectly true within the Manchester Region that the mental hospital population is running down. In the last eight years, for example, Lancaster Moor has gone down by nearly 1,000 patients and is now 190 off its 1975 target. Whittingham has gone down by about 750 and is now 350 off its 1975 target; Prestwich, which has a most extraordinarily difficult catchment area, vast in numbers and scattered in region, has gone down by over 500 patients in this time, and is now just over 400 short of its 1975 target; Parkside has reduced by about 200 and is now 350 off its 1975 target. Thus, there has been a reduction, and in some cases resolution, of the overcrowding; not by the Units "creaming the therapeutic potential" but by their taking all cases and not using the mental hospital at all.

In the overall Hospital Plan there is envisaged a reduction in mental hospital beds; 20 hospitals are to disappear, and others are to be reduced in size. The number of hospitals with 1,000 or more beds is to go down from 69 to 26. All this forecast was to come true by 1975.

Today, nine years off the target date, the picture shows a great deal of confusion. Some of the hospitals given the message of extinction have in fact slightly increased or retained their number of beds and are proceeding with an enhancement of their diagnostic and treatment facilities. Others, such as in the Manchester Region, are very much ahead of the run-down to their 1975 target and many others occupy a middle position, trying to draw conclusions from the information already available, and in most cases planning some sort of integration between the general hospital department and the mental hospital.

Any reasonable conservative approach would, of course, consider an active integration between psychiatric hospital and Unit as a *sine qua non*, if for no other reason than the overall paucity of nursing and psychiatric staff. In Manchester there is little integration and as the plan progresses there will probably be less. For this there is one good and simple reason: such consultants have enough and more to do in their own departments.

What, then, is the future of these mental hospitals? It is well known that there are plenty of problems in psychiatry hitherto neglected. For example, there was the Cohen Plan, now over ten years old, envisaging special epileptic units; few, if any, of these have been formed. There is the ever present problem of alcoholism; beds are needed for children and adolescents. The treatment of the psychopath in the Region is minimal.

At Lancaster Moor we are fortunate. for the new District General Hospital at Lancaster will have no psychiatric beds, as the Admission Unit of Lancaster Moor is only half a mile away. And as a corollary to our patient population run-down we have been able to give much accommodation to other specialities, including blood transfusion, whose needs were clamant and real. Such an introduction of new disciplines forming a McKeown (6) concept of having acute, chronic and mentally sick in one hospital area, has done much for morale and interest amongst the staff, especially nursing, as well as catering for urgent medical and nursing needs in the local area.

This, then, is the picture of the psychiatric services in the Manchester Region. Some people meet it with enthusiasm; others meet it with a great deal of scepticism; but all the evidence is that the treatment in these Units is just as effective and as good as in the large mental hospitals. In June, 1965 Hoenig and Hamilton (7) published a paper on extramural care of psychiatric patients. They investigated Burnley on a four-year follow-up study. They found that ·4 beds/1,000 were sufficient to cater for psychiatric needs without recourse to long-stay admission. "No part of the service seemed overlooked and, on the whole, patients and relatives seemed satisfied."

If my picture of the Manchester Plan appears ambivalent, it is an accurate mirror of my own mind, somewhat divided between an admiration for the work these units carry out and a constant fear of gentle decay and demoralization in the large mental hospital. The moral is that the mental hospitals should not be allowed to confine themselves to the care of long-stay patients, but that parts of them should be used for other real needs and for other real purposes.

References

1. *A Hospital Plan for England and Wales*. Cmnd. 1604. Jan., 1962.

2. Smith, S. (1960). *Review of the Psychiatric Units associated with General Hospitals in the area of the Manchester Regional Hospital Board*. Report to the Manchester Regional Hospital Board.

3. Maclay, W. S. (1958). "Experiments in mental hospital organization." *J. Canad. med. Ass.*, **78**, 12.

4. Silverman, M. (1961) "A comprehensive department of psychological medicine." *Lancet*, Sept. 9. 698.

https://doi.org/10.1192/S0007125066307792 Published online by Cambridge University Press

5. LEYBERG, J. T. (1959). "A district psychiatric service: the Bolton pattern." *Lancet*, Sept. 5th. 282.
6. MCKEOWN, T. (1958). "The concept of a balanced hospital community." *Lancet*, *i*, 701.
7. HOENIG, J., and HAMILTON, M. W. (1965). "Extramural care of psychiatric patients." *Lancet*, June 19th, 1322–1325.

SOUTH-EASTERN DIVISION

THE SPRING DIVISIONAL MEETING was held at Shenley Hospital, St. Albans, Herts., on Wednesday, 6 April, 1966, by kind invitation of the Hospital Management Committee, and of Dr. B. Gilsenan, Chairman of the Group Medical Advisory Committee and his medical colleagues.

Members visited centres of special interest, including Villa 21, Villa 10, a mixed admission unit, the mothers and babies unit, the occupational therapy departments, the industrial unit, and the medical administrative offices. They were afterwards entertained to lunch, at which the Chairman of the Hospital Management Committee, Mr. A. P. G. Walters, welcomed the Association to Shenley, and briefly surveyed plans for the psychiatric organization in the future. Replying on behalf of the Association, Dr. Hardwick, Chairman of the Division, expressed his gratitude for the most interesting arrangements made by the Hospital.

The Minutes of the previous Meeting held at Leavesden Hospital, Abbots Langley, Herts., were read and approved.

The Divisional Committee of Management's Report referred to the Special Adjourned Annual General Meetings held in London on 20 November, 1965 and 11 February, 1966. At the November Meeting the proposals relating to the substitution of Branches for the Divisions were carried with the following amendments:

1. Candidates for Chairmanship of Branches and Special Divisions shall be proposed and seconded by meetings of the Special Executive Committees.
2. When Representative Members of Council are elected, deputies shall also be elected to act in their place if the principal cannot attend.

The new Bye-laws would have the effect of dissolving the present South-Eastern Division; this would be replaced by the Southern Branch, consisting of the present geographical areas comprised by the South-East and South-West Metropolitan Regional Hospital Boards.

The Committee had the current policy of the Ministry of Health in relation to the merging of psychiatric hospital groups with the general hospital groups under discussion, and further information was being sought from the Psychological Medicine Group of the B.M.A. and from the Parliamentary Committee of the R.M.P.A.

The following Officers, recommended by the Divisional Committee of Management, were elected unanimously:

Chairman	Dr. B. M. Gilsenan
Secretary	Dr. A. J. Oldham
Assistant Secretary	Dr. D. M. Leiberman
Junior Representative on Council	Dr. I. G. Christie

Members of Committee:
Drs. Russell Barton, A. Graham, G. P. Hartigan, A. M. Edwards, P. G. Woolf, J. Bruce.

The following were elected ordinary members of the Association:

ATSYOR, JOHN OLYMPIO KWESI EKUDI, M.B., Ch.B., B.A.O., Clinical Assistant, Bethlem Royal and Maudsley Hospitals: Maudsley Hospital, Denmark Hill, S.E.5.
Proposed by Drs. G. F. M. Russell, D. L. Davies, E. H. Hare.

BOYD, PHILIP RALSTON, M.B., B.S., M.R.C.S., L.R.C.P., Clinical Assistant, Academic Department of Psychiatry, Middlesex Hospital, London, W.1.
Proposed by Drs. J. M. Hinton, A. K. Crisp, N. Moore.

COCHEME, MANUEL ALFRED XAVIER, M.A., M.B., B.Ch., D.T.M. & H., D.P.M., Consultant Psychiatrist, West Park Hospital, Epsom, Surrey.
Proposed by Drs. P. A. Bachrich, H. J. Stott, J. Merry.

CULLEN, PATRICK JOSEPH, M.B., B.Ch., D.P.M., Registrar, Halliwick Hospital; 75 Lady Margaret Road, London, N.W.5.
Proposed by Drs. S. Benaim, E. Larkin, J. T. Bruce.

EVANS, DAVID GWYN, M.A., B.M., B.Ch., D.P.M., Registrar, St. George's Hospital, London, S.W.1.
Proposed by Drs. P. B. Storey, P. R. Evans, D. H. Dick.

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