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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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FACT AND FICTION IN THE CARE OF THE MENTALLY HANDICAPPED

DEAR SIR,

The following points appear relevant to Dr. Shapiro's plea for the reversal of policies set out in *Better Services for the Mentally Handicapped* (1) and for the unidisciplinary management and co-ordination of services by psychiatrists.

1. There are some 60,000 mentally handicapped people in hospital in England and Wales and more than twice that number living at home.

2. There are about 130 whole-time equivalent consultants in mental handicap in England and Wales.

3. On average, each consultant is involved in the setting, attaining and monitoring of goals for the 24-hour management of no fewer than 460 hospital patients. There is a similar number of severely handicapped people living at home. Even if the number of consultants were doubled, each consultant's case load would be more than 200 in hospital and 200 at home.

4. While there is evidence of organic pathology in the central nervous system of some mentally handicapped people (2) we are able to identify causes in only a small proportion (3) and to manipulate the organic variables identified (e.g. chromosomes) in still fewer.

5. The bulk of the 'management of life patterns' of mentally handicapped people is carried out by parents and other relatives, teachers, nurses, social workers and remedial therapists.

Dr. Shapiro acknowledges that 'a comprehensive, integrated service is essential to the provision of care under optimal conditions . . .'. Perhaps his objections could be resolved on this basis. The delivery of such a service will only be possible if individual goals are agreed jointly between all involved with each client. It is clear that teaching skills and the skills of organizing team work are likely to feature prominently.

It is unclear how the Mental Deficiency Section's recommendations, involving the creation of academic departments and professional chairs, more clinical research and clinical training, will hasten the advent of individual programmes and collaboration between professionals and relatives. Clarification would enable Dr. Shapiro's proposals to be judged against current policy.

Government targets for the implementation of the White Paper policies are very low, and recent cuts have impeded progress further. Unclear criticism in the absence of clear alternative proposals would appear likely only to weaken attempts to provide the resources required for comprehensive individual care of mentally handicapped people.

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DEAR SIR,

I fully agree with Dr. Kushlick and Mr. Blunden when they say that the present medical staffing of services for the mentally handicapped is grossly inadequate. I also agree when they suggest that it will be a long time before we shall be able to afford the luxury of adequate establishments; but this surely makes the pursuit of prevention (which can only be achieved by intensive research) and rational deployment of available resources all the more imperative. This is why I consider the present attempt to do away with the existing system of care to be as injudicious as it is short-sighted.

I am surprised that Dr. Kushlick limits the medical involvement to concern with organic causes, a strange profession of belief in a member of our College, and considers what is in effect social psychiatry to be only a 'matter for concern for parents, tutors, nurses, etc.'.

It is true that in the practice of mental handicap, as in all other branches of medicine, we rely heavily on the help of associated professions and disciplines but this in no way invalidates the primacy of medicine in the provision of treatment and care, whether for neuro-surgery, paediatrics, obstetrics or mental handicap.

The director of research of an M.R.C. Unit, working under the auspices of a University Faculty of Medicine, surely cannot seriously query the advantages of academic departments and professional chairs which would stimulate more clinical research and improve clinical training!

It is a surprising fact that in this country, although there is a comprehensive network of chairs in general psychiatry, as well as chairs in forensic psychiatry and child psychiatry, and two chairs in psychology of mental handicap, there should not be a chair devoted to mental handicap as such.

One can be forgiven for assuming (particularly after reading Sir George Godber's paper) that this lack is part of a deliberate attempt to minimize the involvement of medicine in the care of the mentally handicapped and to hinder the improvement both of the quantity and the quality of consultants in the specialty. Against this background of official neglect and disparagement, which has Dr. Kushlick's blessing, it is not for my recommendation and those of the Mental Deficiency Section of the College 'to be judged against the current policy', but rather for the current official policy to be judged against the dismal record of the deterioration of the services of the provision of care. Thus:

1. The service previously integrated under medical guidance has been dismembered into separate medical, social and educational services.

2. The present services have attained under medical guidance impressive achievements in the provision of multi-disciplinary treatment and care, both in the hospital and in the community, and any shortcomings in it can be directly attributed to lack of money, facilities and official discouragement. The process of replacement of the existing method of care by any other, even if it were in the long run equally satisfactory, is bound to be very costly and would produce further deterioration in the quality of care during the interim period through lack of availability of alternative personnel.

3. The services, such as they are, have ground to a stop. The hospitals are being run down without prior building up of community services to take their place, if only because the cost of their provision is very much higher than was predicted. It is now more difficult to return a rehabilitated patient into the community than it has ever been before. At the same time, the hospitals with their reduced beddage are incapable of admitting desperately urgent cases, subjecting patients and their families to intolerable stress.

4. The academic status of the specialty is disparaged to the point when a man like Professor Berg (whom Dr. Kushlick quotes in his letter) has been forced to emigrate to Canada to obtain both research facilities and academic status which he could not get in this country. Consequently morale in the profession is low and recruitment is becoming more difficult. The nurses, equally discouraged by the reorganization and by Briggs, see their career prospects dwindle.

When Dr. Kushlick and Mr. Blunden say that 'Government targets for the implementation of the White Paper policies are very low and recent cuts have impeded progress further' they do not appear to realize that these events are built-in consequences of a policy which is not only ill-considered and ill-designed but also one that has not been tried for feasibility, particularly under present economic conditions.

I agree that 'unclear criticism in the absence of clear alternative proposals' are to be deprecated but I submit that it is for the Department of Health and Social Security and Dr. Kushlick to defend if they can the alternatives which events have already shown to be unworkable.

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INTERACTION BETWEEN DEPRESSED PATIENTS AND THEIR SPOUSES

DEAR SIR,

Mary Hinchliffe *et al.* (*Brit. J. Psychiat.* (February 1975), **126**, 164–72) present a fascinating analysis of the interpersonal behaviour of patients with depression. However, despite their conclusion, the evidence does not support their hypothesis that depressive behaviour is maintained by the behaviour of others. To do this, it would be necessary to show that a patient's communication with a stranger showed a communication pattern which was closer to the communication pattern with his spouse on recovery.

Including all the data where communication with the stranger was recorded, one finds seven conditions in which there appeared some improvement (overall expressiveness for male and female, negative expressiveness for male and female, objective focused movements for slow speaking, and body focused movements for slow and fast speaking), and five conditions where the contrary occurs (positive