which we do with the Samaritans. I have discussed this with Dr J. L. T. Birley, who is the medical consultant to the Samaritans, and he agrees with me that it would be useful to organize a meeting which would take place at about the same time as a quarterly meeting of the College.

It would be an informal meeting and as such we cannot expect it to be included in the already busy programme of section, group and other business meetings which are held between the formal sessions of a quarterly meeting. What is proposed is a meeting which would take place on the afternoon or evening before a quarterly meeting or on the evening or morning after a quarterly meeting.

Since there will be a session on parasuicide at the Autumn Quarterly Meeting to be held in London on 14 and 15 November 1985 this might be the most appropriate opportunity, but we could meet at the time of one of the other meetings. If other branch psychiatrists are interested, I would be grateful if they would let me know.

KEITH J. B. RIX

St James's University Hospital
Leeds

The 'Ivory Tower' vs. 'the poor nation of others'

DEAR SIRS

I read with interest Professor Goldberg's comments on my article (*Bulletin*, April 1985, **9**, 83) and his statistical 'evidence' that the University Hospital of South Manchester relatively gives better patient care, with less resources, to a larger population than Prestwich Hospital, while at the same time it conducts far more teaching and research. The inevitable conclusion from this paradox, Professor Goldberg would no doubt have us believe, must lie in the superior intrinsic quality of his academic staff; and this is, indeed, the issue I wish to contest, i.e. the widely held but erroneous view that academic excellence implies, as if by definition, good patient care.

While agreeing with Professor Goldberg that the two terms are not contradictory, I maintain they are distinct and not interchangeable, e.g. asking for money for patient care when you want money for research. The advantage really lies where resources go and patient care should, certainly more often, be given priority.

VICTOR S. NEHAMA

Prestwich Hospital
Manchester

DEAR SIRS

Without wishing to be too pedantic, or to prolong the argument, I feel that I must comment on Professor Goldberg's assertion (*Bulletin*, April 1985, **9**, 83) that the Ivory Tower in Manchester undertakes equal or greater patient care compared with the 'poor nation of others'.

As any researcher will know, we must compare like with like and a more accurate comparison would be, Ivory Tower DGH versus North West Peripheral DGH. Professor Goldberg is well aware of the results of that analysis.

In addition, Professor Goldberg's assertion that 45 per cent of his referrals come from outside the catchment area is well covered by the funding of several Regional Units at his hospital. Our own District's figure of 33 per cent from outside the catchment area is covered by no such Regional funding.

MICHAEL A. LAUNER

Burnley General Hospital
Burnley, Lancs.

[We invited Professor Goldberg to reply—Eds.]

DEAR SIRS

My letter was not intended as a criticism of my colleagues at Prestwich Hospital, but merely as a defence against Dr Nehama's original suggestion (now withdrawn: thank you) that there is some necessary antithesis between academic psychiatry and patient care. I quoted a few figures to make the point that we do not lean on our spades where clinical work is concerned, and I am very pleased that Dr Tarsh has, on behalf of his colleagues, publically disassociated himself from Dr Nehama's original article by acknowledging that we do 'do a very large amount of excellent clinical work' (*Bulletin*, June 1985, **9**, 122).

I may have annoyed my consultant colleagues at Prestwich by drawing attention to the fact that they are not under-resourced. Dr Tarsh now writes that resources being spent on us should be spent in areas from which our patients originate: this is of course already being done, and in the long run it will hurt Salford perhaps even more than South Manchester.

I have considerable sympathy with Dr Launer's letter. Of course I am 'well aware of the results of that analysis', since I was responsible for actually carrying it out.[1] The standard DGH model service is seriously under-resourced in terms of total medical staff, nursing staff and 'other therapists', and it is therefore cheaper than ours, and very much cheaper than services based upon the mental hospital.

Your correspondents are all wide of the mark concerning patients attracted into the teaching area. Dr Launer is wrong in supposing that they are 'covered by funding of Regional Units'; Dr Tarsh is wrong in supposing that improving services peripherally will solve the problem (and also seems unaware of the cross-border flow into Salford!); and finally, Elaine Murphy is quite wrong with her silly and ill-informed sneer that our patients from outside are 'middle class people with minor ailments and a good prognosis' (*Bulletin*, June 1985, **9**, 121-22). I have worked in London teaching hospitals for much longer than she has, and can assure her that what may have been true of them once is certainly not true of us now. The point is worth stating, not only on our behalf but on behalf of Guy's, which is faced with dwindling resources every bit as much as we are: *tough cases are referred to teaching hospitals*.

A significant proportion of my clinical work load are people referred by their GPs for a further psychiatric opinion, as well as many cases referred directly by my consultant colleagues. There is nothing 'shameful' about such work: if Professor Murphy does not do it, there is something peculiar about her academic unit. However, I am sorry I made her blood boil, since that was presumably responsible for the meaningless

numbers she produced. I suggest a long drink of cold water.

It seems to me to be a great pity that we should all be agreeing meekly with the politician's diktat that if resources are to be improved in the periphery then this can only be done by allowing services to deteriorate at the centre: we are heading for an NHS that is uniformly under-resourced, with satisfactory conditions only for those in the private sector (who may indeed be middle class, and have relatively minor illnesses). If we dissipate our energy in attacking one another, and no one stands up for a better NHS with adequate resources at both teaching hospital and peripheral unit, we shall have no one to blame but ourselves. And that really would be shameful.

DAVID GOLDBERG

University Hospital of South Manchester
West Didsbury, Manchester

REFERENCE

[1]GOLDBERG, D. (1985) *Implementation of Mental Health Services in North West England*. Paper presented at the Royal College of Psychiatrists/DHSS Conference on Mental Health Service Planning held in March 1985. Publication of proceedings in preparation.

[This correspondence is now closed—Eds.]

Experience of a community-based approach to alcoholism

DEAR SIRS

Intoxication is a maladaptive coping mechanism which disrupts family life, produces a familiar toll of deaths from ill health, injuries on the roads in accidents, in assaults and vandalism and in suicides. For the less disturbed psychiatry will offer re-education in coping strategies which can offer an alternative to intoxication by drink or drugs.

There is difficulty in dealing with these re-educative areas in the Health Service as the most effective treatments involve psychotherapeutic techniques often over long periods of time. Patients with drink and drug problems often need the help of long-term support groups. Relapse may also be frequent and disheartening for both patients and therapists.

The cost of providing manpower for such treatments offered by statutory health authorities is potentially far greater than the cost of the machinery for high technology medicine. Despite the identification of psychiatric services as priority areas for health expenditure, it remains a Cinderella specialty when funds are distributed. Despite the conflict between rising costs and rising expectations for quality of health care there is a popular and therefore political demand to improve these psychiatric services.

One solution is for the NHS to work in close collaboration with voluntary agencies. An example in the field of addiction treatment and prevention is ACCEPT—an acronym derived from Alcoholism Community Centres for Education, Prevention and Treatment. ACCEPT is a charity which operates day centre treatment facilities offering a wide variety of sophisticated psychotherapeutic techniques which would be envied by most psychiatric day hospitals. As part of my higher professional training at St George's Hospital Medical School I have been able to spend time working at ACCEPT's major centre in Fulham, which deals with upwards of 100 new cases per month.

This has been a fascinating experience with several benefits. I have had access to the clients there and have therefore been able to see a much greater range of presentations of addiction problems than that afforded by the patients referred to psychiatric services or even presenting in general practice. I have also learned how to work with the lay and voluntary workers and allow them to make use of my skills and obtain psychiatric advice for their clients. I have conducted group and individual therapy and been able to offer this to people who could not have been prepared to participate in such treatment under a label of psychiatric treatment, but who found attendance at a community agency fully acceptable.

The quality of intervention and its continuity of therapists over time is remarkable and better or equal to that of the best neurosis units in the health service whose numbers are, of course, very limited because of their high costs. I have also been able to gather research data from the client group to further my own interest in addiction problems.

I have found my experience very worthwhile and suggest it would be a useful model for the future. It shows that both training and service functions can be provided by voluntary agencies in co-operation with the NHS and that they complement each other and achieve good results as well as significant financial savings. The experience also brings community involvement in psychiatric care to life with the committed involvement of both sides which is essential for any real success.

ROBERT HILL

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Education in health care of people with mental handicap

DEAR SIRS

In the past most doctors have often received little undergraduate or postgraduate teaching about mental handicap. That they have often been at a loss to help mentally handicapped people has been noticed by the parents of mentally handicapped children. Specialists in Developmental Paediatrics and Child Health have seen an increasing proportion of, but never all, mentally handicapped children. General Medical Specialists treat mentally handicapped people referred to them with particular complaints, but they are not concerned with these patients' lives as a whole.

A need for more teaching of doctors about mental handicap is emerging so that family doctors can help the mentally handicapped more confidently. Continuing specialist help is also required for a variety of problems. Teaching on mental handicap has tended to become a catalogue of relatively rare conditions, but today there is an opportunity to develop teaching more widely as the 'health care of people with mental handicap'.