It was certainly not an attempt to offer a formula for 'a comprehensive service'. Still less was it intended to set the pattern of mental health care in tablets of stone. I hope, though, that members may find it useful as establishing a starting point for discussion. If, for instance, their local administrators accepted such norms, with qualification, for a 'bed-led' service, then they might be sympathetic to alternatives which would cost less, or at least no more. Unfortunately many of our members find their existing resources are whittled away to very unsatisfactory levels. It is not easy for them to defend themselves unless they can quote figures. Dr McGovern is right in supposing that my letter was well intentioned, but not necessarily to assist psychiatric planners to 'obtain more resources'—sometimes to help them to avoid losing what they have at present. I fully accept that any discussion of bed norms must be hedged around with many qualifications before being translated into beds.

R. G. PRIEST
Registrar

Consultant psychiatrist in mental handicap

DEAR SIRS

I read the article 'The Role of the Consultant Psychiatrist in Mental Handicap' by Caroline Marriott (*Bulletin*, December 1986, **10**, 347–348) with much interest.

Dr Marriott seems to support the view that the Consultant Psychiatrist in Mental Handicap should take a full share of *all services for the mentally handicapped*—albeit endorsed by the DHSS (NI) in 1978. I feel that, for far too long, services for the mentally handicapped have been unsatisfactory because of the concept of the Consultant in Mental Handicap, dealing with mental to dental problems of the mentally handicapped.

The admission of a large number of mentally handicapped people (irrespective of their needs) to hospitals for the mentally handicapped aided and abetted this concept. As a direct result of this, other medical specialists and General Practitioners got used to the idea that any medical problem should be dealt with by the Consultant in Mental Handicap.

The role of Consultant in Mental Handicap has crystallised at last and most Consultants would prefer to call themselves Consultant Psychiatrist in Mental Handicap, which has the blessing of the Royal College of Psychiatrists as well.

The Consultant Psychiatrist in Mental Handicap should practise psychiatry and leave non-psychiatric medical problems to generic services. In fact, Dr Marriott mentions that "Consultants in Mental Handicap must work closely with all other medical and non-medical professionals likely to be in contact with mentally handicapped people."

But the initiative of disengaging from non-psychiatric problems and making other medical specialists and General Practitioners interested and involved in the problems of the mentally handicapped must come from Psychiatrists in Mental Handicap. It is easier said than done but can be achieved with energy, enthusiasm and persuasion and, most importantly, by face to face approaches to all the people concerned, as many medical specialists of different disciplines and General Practitioners need education, re-orientation and reassurance in order to deal with the problems of people with mental handicap.

With the rotation of junior psychiatric posts in Psychiatry of Mental Handicap, in the course of time General Psychiatrists should be able to cope with the psychiatry of mental handicap and joint appointments will occur more frequently, but in every district there is a need for at least one full time Consultant Psychiatrist in Mental Handicap. This will go a long way in changing the attitudes of the laymen and professionals and in re-organising hospitals for the mentally handicapped, with a reduction in the number of beds (and in smaller accommodation, preferably bungalows 4–6 bedded with single rooms) and developing community homes, some of which, ideally, will have to be run by the NHS.

The job of Psychiatrist in Mental Handicap is extremely interesting, fascinating and challenging but it could be very dull, depressing and thoroughly frustrating depending on what we make of it and how able we are in initiating changes and how successful we are in making others accept these changes.

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Prejudice and mental handicap

DEAR SIRS

I was recently shown a copy of *Public Service*, NALGO's publication for December 1986, in which it was reported of Sir Brian Rix, the Secretary-General of MENCAP, "The mentally handicapped", he declares, "don't need locking up, they don't need drugs or psychiatrists".

Shortly after reading this I was asked urgently to see a mentally handicapped young man who had become agitated and had begun to attack his elderly parents. Under my care at present are a mentally handicapped man who has killed, another who has threatened people with a knife, and a woman who has set fires. On Christmas Day I received a call from a duty social worker anxious about a mentally handicapped man who was enjoying this community care by ordering about his ailing father and mother after having broken most of their crockery.

It is a pity that in mental handicap time and energy appear still to be dissipated on denigrating hospitals, where the vast proportion of patients since 1959 have been informal and not locked away, on sniping at psychiatrists, and perpetuating divisiveness. In practice over the years the difficulty has been attracting psychiatrists to take an interest in mental handicap, not the opposite. In fact the trend away from institutional care for mental handicap has paralleled the growth in the number of psychiatrists in this field and their general philosophy of not hospitalising mentally handicapped people, but developing out-patient and community support services.

Psychiatrists who have more than enough work to do are well aware that the large majority of mentally handicapped people, as with the general population, happily do not need their attention, but a small minority do. Their interests are best served by a broad eclectic approach which can offer mentally handicapped people a range of residential options to meet their needs through, for example, the parental home, fostering, staffed and unstaffed flats and houses, group homes, hostels and hospital, of occupational options such as training centres, special care units, sheltered workshops and continuing education centres, and advice from a range of specialists, psychiatrists, psychologists, nurses, physiotherapists and dietitians.

Community orientated services for mental handicap are the avowed objective in future NHS planning, which if fulfilled will see the dissolution of large mental handicap hospitals by the end of the century. Now mentally handicapped people can look forward to the promised land of community care. Mental handicap should be striving to reach beyond the obsolete prejudices of yesterday.

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Medical aspects of fitness to drive

DEAR SIRS

I wonder if the College is aware of the facts of the document which is published by the 'Medical Commission on Accident Prevention' which is supported by the Royal College of Psychiatrists.

I had a man aged 46 in my out-patient clinic with depression whose Heavy Goods Vehicle Licence had been removed from him because he was on medication for his depression. Because he had lost the HGV licence he was sacked by the bus company for whom he had worked for 13 years. His Union finally advised him that he could not fight this dismissal but he should go for a pension. Working with the Senior Medical Adviser to the Transport Executive I discovered that he was not eligible for a pension unless he was going to be continuously ill for the rest of his life.

Because this man has had a depressive illness, which is now under treatment, he is now unemployable, although in the normal course of events one would expect him to recover quite easily. The worry of all this and the financial strain have upset him even more which is making his depression harder to treat, naturally.

It seems to me quite wrong that somebody should lose their job for ever because of a treatable psychiatric condition. Would it be possible for some recommendations to be made for patients like this, that they are only temporarily prevented from driving and their HGV held in abeyance until they have recovered.

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'Psychoanalysis—Science or Nonscience?'

DEAR SIRS

I am delighted that my article 'Psychoanalysis: Science or Nonscience?'[1] has stimulated such lively debate in the correspondence columns of the *Bulletin* and the *British Journal of Psychiatry*. My critics Thompson, Wright and Anderson unanimously assert that nonscience is not the same as nonsense, and confirm that Popper in fact did not imply this; my point was that some colleagues use their own notions of what constitutes science (often drawn from Popper) to dismiss any body of knowledge that does not conform thereto, designating it as not worth considering, and therefore as nonsense.

My intention was to widen the debate as to what constitutes knowledge, and therefore science, and to encourage new formulations. I was disappointed that the above-mentioned gentlemen appeared not to have read further than my critique of Popper, which did not form the main bulk of the article. Nevertheless, I would like to comment on some of their points.

I agree with Wright when he says that falsifiability and testability 'are the same in the sense in which they are used by Popper'; my point is that they are not of necessity the same—a theory can be tested by showing it to be true or false. An example of testing by verification (which Thompson requests) is the prediction of future events by a theory, such as the prediction of the existence of planets which were later discovered. Even when theories are falsified they are not rejected but remain true and are used at different levels of explanation (Wright uses my example of classical versus relativity theory). This is why transcendental realist theory with its emphasis on different levels of explanation is a more interesting and practically useful model.

My basic point is that there is nothing magical about falsifiability as a criterion of scientificity. It seems a neat and useful tool at face value, but on deeper examination it is subject to the same logical problems as verifiability: both require an external or *a priori* criterion which is separate from the theory to be tested. To use a Popperian example: the conjecture that 'all swans are white' can only be refuted if one has some prior knowledge, namely that 'swan-ness' is not the same as 'whiteness'; otherwise the existence of a black creature that looks like a swan could not refute the conjecture. Indeed Popper's theory has been called 'a version of inductivism' (Harre),[2] retaining as it does one of the inductivist principles, namely the principle of accumulation; that science is the accumulation of well-attested facts (attested by the use of falsifiability criteria). Harre further says that experimental evidence alone is insufficient to confirm or refute a theory; other rational procedures of decision are necessary; science is a complex activity and cannot be described as simplistically as Popper does.

Psychoanalysis constitutes a body of theory which seeks to explain intrapsychic phenomena; the theory of resistance to therapy is not an 'ad hoc theory' (Wright) but is part of the general theory, which operates at different levels of