system based on researched and proven methods, could disintegrate if such opinions were taken seriously.

There are two main factors which perpetuate the current, unsatisfactory situation. Firstly, the rules of reporting on visits protect the HAS from change. At the feed-back session given by the visitors, questions from and discussion by the audience are not allowed. The draft report which follows, and whose circulation is usually restricted, is apparently sent with the instructions that only 'factual' errors should be corrected and that no comments should be made. Secondly, while the final report is in danger of being adopted by managers as their 'bible', clinicians are reluctant to criticise or ignore parts of it, in case the whole (including sound advice) is discredited in the eyes of health authorities.

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DEAR SIRS

Professor Goldberg and his colleagues in South Manchester (*Bulletin*, February 1986, **10**, 36) question the methods of operation of the NHS Health Advisory Service and, in particular, the advice which was recently offered about their mental illness service. What we actually said in our Report about South Manchester and the advice it contains are matters of public record and interested observers would be welcome to have copies. They would find major discrepancies in style and content between the Report and the distorted interpretation now being put forward.

I will try to answer the four questions the letter poses, while avoiding the bluster and moving goalposts of the South Manchester arguments. To do so is important, not least to reassure those not recently visited by the Health Advisory Service who might justifiably fear any review conducted in the way that Professor Goldberg describes.

The Health Advisory Service does not 'hold strong beliefs'. There is no HAS philosophy and neither does HAS issue checklists, guidelines or advice to team members on desired organisational or therapeutic solutions. Instead teams are asked to bring their own experience of psychiatry to bear on a local situation, to comment on the weaknesses and strengths which they perceive and to give advice. Selection of team members is based on wide consultation and is constantly reviewed. Psychiatrists participating in the work of the Health Advisory Service have included many of the social psychiatrists to whom your correspondents refer.

We do not, and have no power to, 'impose' solutions. Neither do HAS Reports 'instruct', 'disrupt' or compel 'rigid' requirements. What each Report offers is *advice*, based on the wide experience of professional colleagues with no axe to grind and unencumbered by local history and politics. In the vast majority of visits, such advice is welcomed and seen as valuable support by clinicians battling to promote their services. In the process of following up our visits, there is less emphasis on whether advice has been carried out than on whether the problem to which our advice was directed has been overcome.

Making HAS advice locally relevant is given great emphasis. Teams usually spend no less than three weeks in the district under review, listening, observing and testing the applicability of their ideas. Much of the advice eventually offered is derived directly from local opinion, released by the informal processes of the visit. Each visit includes contacts with general practitioners, community health councils and voluntary organisations as well as all grades of staff in health and social services departments. Our reports contain few 'stock' solutions; instead they represent the best combination of the team's experience and the local situation.

Since Reports are not verdicts there is no question of 'appeal'. It is open to those receiving them to disregard their content and advice. Nevertheless great efforts are made to ensure that Reports are correct. Psychiatrists are able to review a draft version of the report, and propose amendments where the team has misinterpreted its findings, before publication. In the case of South Manchester, your readers will be interested to know that detailed collation of local medical opinion occurred followed by a further visit to the District by myself. As a result, the Chairman of the Division of Psychiatry (not a co-signatory of the letter you published) wrote to thank HAS for a document which was 'a very helpful contribution' which 'will help us in our efforts to develop better services from the base which we now have'.

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Nigerian psychiatry

DEAR SIRS

I have recently gone over a very interesting collection of papers *Psychiatry in Developing Countries*,[1] but would like to comment on the paper on Nigerian psychiatry written by Ayodele Obembe.

Nigeria, as you know, is a multi-national, multi-lingual and therefore multi-cultural state and it is in fact this diversity of culture that has been one of the greatest problems of that country. What Obembe's paper describes is really the practice of psychiatry in the Yoruba areas of Western Nigeria rather than the practice of psychiatry in the whole country. The terms used in his description of certain aspects of psychiatric practices, such as *Babalawo*, *Onisegun* and *Olarisa* would only be comprehended in Western Nigeria and would have no relevance to any other part of the country.

I thought it might be important to insert this clarification for the benefit of all those who come across this fine selection of papers.

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REFERENCE

[1]BROWN, Stephen (ed.) (1983) *Psychiatry in Developing Countries*. London: Gaskell (The Royal College of Psychiatrists).

https://doi.org/10.1192/S0140078900027346 Published online by Cambridge University Press