With the short courses a statement of attendance is offered. The Joint Board is therefore offering a mixture of postgraduate training leading to the equivalent of Diplomas and Membership of the various Colleges and the general practitioner requirement to attend a number of postgraduate meetings during the year. They do it differently—some would say that they do it better and that the doctors should emulate them. In the meantime it is important that doctors should be aware of the activities of the Joint Board, should encourage nurses to attend available courses and should be aware of courses in their own field which they should bring to the attention of suitable nurses. Furthermore, when the nurses return it is most important that they should be helped to use the knowledge which has been gained in a constructive and productive manner. There is a need for doctors to press the case for the financing of secondment to courses and also, where appropriate, for the setting up of courses in their own Area. Doctors expect postgraduate training for themselves and should support their nursing colleagues in their claims for similar post-basic professional education and training.*

* Copies of Notes on the Outline Curricula published by the Joint Board of Clinical Nursing Studies and current lists of centres approved to offer courses may be obtained free from the Joint Board at 178–202 Great Portland Street, London W1N 5TB. A stamped, self-addressed envelope accompanying your request would be appreciated.

MYTHS AND 'MIND'

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If the perpetuation of a myth leads to the saving of central Government funds, political parties and bureaucrats will eschew reality.

In such endeavours they will enlist to their aid any pressure group or society that can be easily deceived by fine phrases and ideals. One of the most consistent allies of the DHSS in this duplicity is the National Association of Mental Health.

In their publication 'MIND' October 1977, the position of the Community Mental Health provisions in Yorkshire, Humberside and the East Midlands is examined, the Government publication *Better Services for the Mentally Ill* forming the basis of their critique. There is a tenacity of purpose exhibited by 'MIND' directed towards pressurizing recalcitrant Local Authorities into wasting local finances in order to achieve what will be an inferior service for the mentally ill.

The first of the two myths which are perpetuated in this quest for more Local Authority Residential Care, Day Care and Social Clubs was created in 1961, postulating that mental hospitals would cease to have a *raison d'être* within a decade.

The second pretension is that mental hospitals produce institutional neurosis where Local Authority Residences do not.

The first myth, continually refreshed and rehearsed by each new Ministry, enables the DHSS to neglect the only solid facility which is available in any quantity to the 'mentally and emotionally ill'—the psychiatric hospital.

The second proposition is equally fatuous, as it is systems and staff attitudes that cause institutionalization, not buildings.

How often does one go into the modern Local Authority Part III accommodation for the elderly and see the institutionalized 'wall-flowers' who have long disappeared from the psychiatric hospital ward? The Social Services have heard of institutionalization but fail to understand its nature and are insistent on repeating the same errors in patient care that psychiatric hospitals learnt to avoid before 1960.

'MIND' states that patients who are well-cared for in hospital find on discharge that no one cares.

One asks, 'were such patients discharged simply to demonstrate to the DHSS that the hospital in question is progressive'? Too often patients are discharged who cannot achieve even primary survival standards in society. Such patients can live to their maximum capacity in one of the 'hostel' wards of a mental hospital, living satisfactory lives, virtually independent of nurses and doctors; moving freely into

the accepting local community. To house such people otherwise, new accommodation would be required which, when built, would prove to be inferior, both in facilities and in ability to stimulate, to the ward the patient has left.

Even in Group Homes, institutionalization, and worse suffering, occurs when unsuitable patients are misplaced or badly supported, or both. Frequent returns to hospital lead to loss of confidence and recurrence of symptoms long encapsulated.

'MIND' states 'Hospital staff work hard to rehabilitate patients to continue to *live in hospital*'. Provided that the rehabilitation is to the patient's maximum ability there is little point in wasting valuable resources in building unnecessary hostel accommodation in which neurosis is likely to be reinforced by psychiatrically unsophisticated staff whose attitudes to patients are 'totally caring' in the most custodial sense.

'MIND', using that abominable cliché 'The Primary Health Care Team' implies that a mere general practitioner might encourage a patient to relate more to a hospital rather than to the community. May this not be because a general practitioner is realistic and can assess where the patient is most likely to receive care in the sense of true rehabilitation and understanding? 'The Health Care Team' is more likely to totally ignore the realities of social demand or the patient's capacity to adapt to such pressures.

A social worker, a psychologist, a nurse or a doctor may come to the right answer if they have individual responsibility for the patient. A 'Health Care' Committee never will, as it is chiefly a device which allows individuals to avoid professional responsibility and reduces true professional competence.

Similarly, a statement that 'Unless Social Services are involved, the discharged patient may be completely out of touch with support network' ignores the real practical position, that most hospital professionals expect nothing from Social Services and arrange their own independent hospital/clinic-based network, which is dependable and works without the patient losing touch with those hospital workers who really care.

An allusion is made to Section 6 of the 1959 Mental Health Act and the responsibilities of the Social Services. This can now be seen as a device of the bureaucrats to reduce and displace the cost of caring and reduce the efficiency by breaking hospital responsibility.

A statement 'Repeated admissions for many patients reflects poor after-care' is neither the whole truth nor as self-evident as the statement seems. Most readmissions are either due to relapsing psychosis or to neurotic adaptions which are based on personality disorders (or to the patient being discharged to an environment less suited to his needs than the mental hospital). It is probable that we have reduced the patient population of mental hospitals far too radically, in an attempt to appease our masters—a reflation of the mental hospital population by 10 per cent is probably indicated.

Local authority day care is next examined by 'MIND'. Again, this is found to be inadequate. It is difficult to see practical advantage in basing such day care away from the psychiatric hospital, unless patients have to travel long distances—in such instances there is a case for satellite day care facilities, but even such facilities would be more reliable if related to the Community Hospital, where real care could be given.

Social clubs are debated. Anyone who has been involved in these will realize that they can be pernicious institutionalizing arrangements, avoided by patients who have regained drive and initiative. The situation reinforces the neurotic dependence of the most vulnerable. The most valuable social clubs have proved to be the hospital-based branch of a national organization such as Women's Institutes or Townswomen's Guilds where the patient, on discharge, can transfer from the hospital branch to that of the locality in which she is resettled.

There might also be a case for evening therapeutic groups, but even these should be directed by hospital-based professionals if effective continuity is to be achieved.

The conclusion reached by 'MIND' continues to make assertions for which there is no evidence or contrary to the evidence, e.g. 'community care is less costly than institutional care' is probably a myth, if the quality of care is equal—but community care is a means of shifting cost from the nation to the locality.

The allegation that community care is more satisfactory from the patient's point of view is only true when there has been real rehabilitation. Simply swapping institutions leads to more unhappiness than it relieves.

Joint planning is advocated, but those who have tried this path have found it a dead end, best avoided, as much time and endeavour is uselessly expended, which could be better channelled into caring for *patients*.

This Report by 'MIND', in seeming to support our cause, is more destructive to the well-being of the mentally ill than former 'MIND' publications, as by giving unfounded credence to indiscriminate community care it allows Government to continue the degradation of the Hospital Service.

Mental hospitals may be Victorian, but they are the best mental health real-estate we have, and, just as Victorian and Georgian houses are often far more satisfactory places in which to live than modern little boxes or high-rise flats, so the hospital is a much more total therapeutic community than the isolated Local Authority institution or neglected Group Home can be.

The mental hospital should be central to all mental health care, and from it, all good mental health rehabilitation and community care should occur, where the social worker commitment is hospital-based and directed.

However, for the mental hospital to reach maximum efficiency, funds must be redirected to it by Government. Its resources should be cherished, not eroded by giving credence to unsubstantiated psycho-social mythology.

The views expressed in this article are entirely the author's own. Ed.

THE SCRIBE'S COLUMN

In Need of Sympathetic Modernization

It is surprising that devotees (and who isn't) of our ever-expanding multidisciplinary psychiatric teams have so far ignored the contribution that could so usefully be made by our colleagues the Estate Agents. Psychiatric hospitals advertising jobs and Estate Agents selling properties share a common problem and a common phraseology. The purpose of this paper is to suggest that we could usefully learn from each other in a properly constituted multidisciplinary setting.

For example, psychiatric hospitals have for many years laid considerable emphasis upon their setting, particularly if rural or marine. 'Situated in pleasant rolling countryside' was for long the proud boast of one of the Southern hospitals which used to add, presumably to distinguish itself from the local Estate Agents, 'all modern methods of treatment practised'. The idyllic picture thus long ago presented was of phenothiazines and psychotherapy generously dispensed in a parkland setting with skies at peace under an English heaven.

Research shows that this rural tradition still continues, as well exemplified by two recent advertisements; the first, from an estate agency, described a house which had 'more than a glimpse of the sea'; the second said (*BMJ*, 1 Oct. 1977, xxxvi) of a psychiatric hospital that it was 'situated in countryside seven miles from attractive bathing beaches'. From the same part of the world, give or take a few miles, another psychiatric hospital pointed out (*BMJ*, 24 Sept. 1977, xxxii) that its vacant post 'would especially appeal to those applicants interested in country pursuits'. While this might have the entirely laudable effect of discouraging the urban denizens of Denmark Hill, it might yet be thought by some to come perilously close to prosecution under the Obscene Publications Act. Both these hospitals were in Wales, and if you can't speak Welsh there is always that hospital which has 'access to the unspoilt and delightful Northumbrian hinterland with its excellent coastline and hills' (*BMJ*, 27 Aug. 1977, xxviii). And if you can't speak English, there is that other hospital which bills itself as 'situated in 200 acres of extensively landscaped Hertfordshire countryside' (*Lancet*, 5 Nov. 1977, p 18). If these advertisements are compared with that recent American one (*BMJ*, 12 Nov. 1977, xlvi) from California for a psychiatric hospital affording 'an opportunity for professional growth and personal enrichment (I like that—E) in a community near beaches and mountains with clear air and unexcelled recreational resources', it will be seen that our American cousins must already have established a multidisciplinary team with Estate Agents.

Both Estate Agents and psychiatrists use advertisements to illustrate recent advances in their respective technologies. Thus the word 'refurbishment' in estate agencies is newly on the scene. In our own discipline one may note such developments as that hospital which alleged that (*BMJ*, 24 Sept. 1977, xxxi) 'A progressive multidisciplinary social psychiatric approach to treatment is practised'. Such compelling, if incomprehensible, attractions carry their own dangers, and this particular one, falling like a thunderclap across the surface of the psychiatric world from Cairo to Karachi, from Menninger to Maudsley,