extending into adult life. We report a small follow-up study which involved 22 teenage soilers (4 girls and 18 boys) admitted to an in-patient psychiatric adolescent unit who were followed up for 2–11 years (mean = 5 years; s.d. = 2 years) after discharge. They had been treated at High Lands Adolescent Unit, Scalebor Park Hospital, Burley-in-Wharfedale, between 1973 and 1983. Mean age on review was 19 years (s.d. = 4 years, range = 15–25 years); mean age at the time of admission was 13.5 years (s.d. = 3.7 years). All were of normal intelligence, and social class was mostly III (Registrar General's Classification). There was associated nocturnal enuresis in eight of them. Average duration of stay in hospital was 5 months (s.d. = 2 months); two were re-admitted. Twelve of them were considered to be conduct disordered, one had obsessional neurosis, one had a severe anxiety state, and one was depressed. Treatment consisted of toilet training, often with supplementary laxatives, therapy and family counselling.

Family doctors provided information on follow-up in all instances. Five former patients agreed to be interviewed, and another eight agreed to complete a review questionnaire. These 13 completed the 60-item GHQ and the Leeds Scale for Anxiety and Depression. It was found that there were three definite soilers between the ages of 17 and 23.

Case reports: (i) A 23-year-old man had been treated at the age of 16 with severe soiling and conduct disorder. Corroborative information came from both questionnaire and family doctor.

(ii) A 19 year-old man who was employed on a high rise building-site had been treated at the age of 14 years, and had subsequently been re-admitted for a recurrence of soiling. He was interviewed at follow-up and said he had a tendency to soil when out of reach of toilets.

(iii) An 18 year-old man who had been admitted at the age of 14 had been considered as conduct disordered and had nocturnal enuresis. Information in his case came from the family doctor, He was still soiling.

None of these three showed any evidence of psychiatric disorder on the GHQ or Leeds Scales.

The family doctors provided a control group selected randomly from their lists. None showed any evidence of soiling, although one 18 year-old had been treated for faecal impaction without soiling. For the 13 who completed the GHQ the mean score was 3.6 (s.d. = 1.9). One individual had a score of 11, indicating possible psychiatric disturbance. He had been treated by a psychiatrist. The mean anxiety score on the Leeds Scale for the 13 was 4 (s.d. = 2) and for depression was 2.3 (s.d. = 1.5).

We would like to thank Mrs B. Morris, who greatly assisted in the carrying out of this small project.

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Clopenthixol in Aggressive Mentally Handicapped Patients

SIR: We read with interest the report by Mlele & Wiley (*Journal*, September 1986, **149**, 373–376). They conclude that "clopenthixol decanoate may be useful in reducing aggressive and disruptive behaviour in mentally handicapped adults". But has this finding any reliability? We do not know whether the effect was specific to depot clopenthixol because "none (of the patients) had been given depot phenothiazines" (presumably meaning depot neuroleptics, because only one depot phenothiazine is available). We cannot be certain that there were beneficial effects, because the ratings of behavioural changes were crude, as the authors observe, and even more importantly, they were not carried out blind to the treatment. A control group having placebo injections would be essential.

The paper is further weakened by the absence of diagnostic criteria for the use of the medication. It is disturbing that potent medication given by injection is being advocated for non-specific behaviour disturbances, which invites accusations of the use of 'chemical strait-jackets'.

We appreciate the diagnostic problems in people with mental handicap and the difficulties in their clinical management, but we think that the administration of drugs for behavioural control, rather than for the treatment of specific diagnosable illness, needs justification. With contemporary multiprofessional interest in behaviour modification techniques and non-institutional care, doctors need to be clearer about the indications for intervention with medication, rather than advocating its use on non-specific grounds.

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Cost of Community Psychiatry

SIR: Hoult (*Journal*, August 1986, **149**, 137–144) is to be commended for the enthusiasm and enterprise he

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has shown in developing an alternative to hospital-based psychiatry in Victoria. However, we are concerned that the figures quoted in his article may be uncritically repeated as showing that his alternative form of psychiatric care, based on heavy community involvement and boarding house care, is cheaper than conventional hospital-based psychiatry and should make hospital care redundant. The standard method of calculating such figures involves the cost of each in-patient day taken as a fraction of the total expenditure of that institution on clinical work. This figure is usually fairly large, and is therefore unlikely to be exceeded by other costs, even when these are relatively complicated such as setting up the boarding house supervision described in Hoult's paper.

Provision of community-based psychiatry, even when it is as effective as that described by Hoult, does not necessarily reduce the cost of hospital psychiatry. A full range of services is necessary to treat the most disturbed patients, a service that was necessary for even some of Hoult's intensively treated experimental group, and if such a service is to be maintained the total cost per in-patient will rise as the number of beds is reduced. Recently, following expansion of our services into the community, we were able to reduce the acute in-patient services from our inner-city sector in Nottingham (population 70 000) from 30 to 18 beds. This involved transfer to a different ward, and was expected to be accompanied by a reduction in nursing staff. However, because of the need to maintain adequate numbers of well-trained staff to deal with the smaller numbers of often disturbed patients, the number of nurses on the ward was reduced by only one. If we had used the standard cost-effectiveness calculations as described by Hoult our community-based service would appear a great deal cheaper, as there have been fewer admissions staying for a shorter time. Significant savings can only be made by running down the hospital end of the service. This would be quite inappropriate, and would lead to a two-tier system whereby all the best care was given in the community and those who failed to remain in community care would receive an inferior form of custodial care in hospital. For this reason we advocate that all community psychiatry should be closely linked with a hospital base so that such a two-tier system cannot develop. The hive system of care (Tyrer, 1985) emphasises the need for staff to work from a hospital base but to have extensive community involvement and, in the longer term, this can only be achieved by rotating staff between hospital and community activities. This has been tried in Sweden (Perris *et al*, 1985) and preliminary results are encouraging.

Despite the enthusiasm and effort of Hoult's experimental team, the fact that some patients needed to be admitted to hospital demonstrates that hospital and community psychiatry cannot exist in isolation. The future lies in integrating the essential components of both, not in abandoning one at the expense of the other.

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Witchcraft and Psychotherapy

SIR: The article by Neki *et al* (*Journal*, August 1986, **149**, 145–155) is not only of relevance to mental health professionals in Africa and other areas of the Third World, but also to those working with immigrant populations in Western countries. The review confirms that beliefs in magic causation are not abandoned under 'Westernising' influences in Africa; in fact, magic beliefs and practices are often intensified under conditions of rapid socio-cultural change, with its attendant psychopathology. This was apparent twenty years ago (Jilek, 1967).

The article conveys an overall negative view of African traditional healers by using the label witch-doctor in a pejorative sense. In colonial times witch-doctor was the blanket label for all 'native' diviners, healers, medicine men, magical ritualists and herbalists. The demise of colonial rule brought a re-evaluation of non-Western therapeutic systems and a more positive assessment of traditional therapists (Jilek, 1971). Neki *et al* convey the impression that witch-doctor is more or less synonymous with sorcerer or witch. There are, however, quite distinct categories of traditional diagnosticians and therapists, with different functions and often specialisations, everywhere in Africa, including Tanzania and even in smaller tribes, as we found out in field work among the Wapogoro (Jilek & Jilek-Aall, 1967). It is regrettable that Neki *et al* fail to find any usefulness in the collaboration between Western-trained health staff and traditional practitioners, pioneered with considerable success by Lambo and his colleagues in

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