easily have been overshadowed by the marked effect of the unknown factor or factors, and Dickson & Kendell's inference about the poor effect of lithium therapy under ordinary clinical conditions is not vindicated by their data. Examination of rates of readmission for manic-depressive patients actually in long-term lithium treatment might have provided information more suited to assess the efficacy of lithium prophylaxis.

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Reference

DICKSON, W. E. & KENDELL, R. E. (1966) Does maintenance lithium therapy prevent recurrences of mania under ordinary clinical conditions? *Psychological Medicine*, **16**, 521–530.

Community Care of the Acutely Mentally Ill

SIR: Whether Hoult's study (*Journal*, August 1986, **149**, 137–144) shows that "it is feasible to treat most psychiatric patients in the community as an alternative to mental hospital care" is open to doubt.

For example, 40% of his experimental group required hospital admission at some time. Certainly this was much less, in terms of numbers and duration, than the control sample, but the latter's rates for hospital admission seem inordinately high. It appears that admission was almost automatic for any control group patient turning up at the hospital. Furthermore, there is for some reason a significant increase in neurotic syndrome scores for this control group, and over one fifth are lost to follow up, despite being local residents. It is also worrying that the most difficult cases in psychiatric practice (those over 65, mentally retarded, brain-damaged and drug/alcohol dependent) are excluded. It is certainly reasonable to have a refined sample for research into aetiology, but assessment of care must surely include all the complicated problems that so often provide the greatest management difficulties. Finally, I am uncertain as to the basis of his costing of the alternative care systems. Does he include the on-call availability of psychiatrists "covering the rest of the catchment area service", and the fixed costs of running a hospital anyway — (regardless of patient usage) — since his patients certainly had to use this resource?

It seems that the problem in this work is the "degree of artificiality" created by a research project. The "assertiveness", 24 hour availability, enthusiasm and job satisfaction of the staff involved are crucial factors, and a false dichotomy between hospital and community care is set up. Yet it is not the "where" that matters, it is the "what" and "who" that are essential. Hoult and his workers have clearly shown that the quality of care, at the personal level, is central to a good outcome in psychiatric illness. They have fallen into the non-scientific trap of obtaining findings that "confirmed our aims" — (where is the null hypothesis in this?) — and have not pursued the obvious control situation, namely putting their motivated research team, and its methods, into the hospital. While it is gratifying to see their success — and the value of having a psychiatrist on-call continually — it may be more realistic to see the hospital as a community resource and not to create either/or contrasts.

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A HUNDRED YEARS AGO

Asylum Reports

YORK. DR. HITCHCOCK REPORTS: "During the winter months I have been giving a course of lectures on elementary anatomy, physiology, and the immediate treatment of injuries and accidents, etc to the nurses and attendants of the asylum. I was much gratified by their regular attendance and the interest manifested in the subject; the more so that several, not specially engaged in attendance on the patients, were amongst my class; even some of the patients asked if they could attend, but I drew the line there. I shall not mind if the knowledge they gained is not tested by practice; but at all events the subject was right and necessary for them to be instructed in, and if all's well I shall give a similar course next year."

Reference

Journal of Mental Science (April, 1886) **32**, 146.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Surrey.

https://doi.org/10.1192/S000712500012224X Published online by Cambridge University Press