Security for a clear and comprehensive statement on what provisions are to be made for the elderly mentally ill. Obviously the Department's document on the future of hospital services for the mentally ill, issued last December, has caused the Association some anxiety. It was made clear that the Department's policy is to move psychiatric in-patient facilities from the large, often isolated mental hospitals into small general hospital units. This is an admirable policy, but unfortunately little has yet been said about what should be done for old people with psychiatric disorders. The suggested general hospital units will not be able to provide anything approaching an adequate service for this group of patients. It has been suggested by some that the psychiatric services should only concern themselves with old people with so-called functional disorders, leaving the large group labelled as demented as the responsibility of either the geriatricians or local authority social service departments. This would mean that the small general hospital psychiatric unit would be able to cope, even with old people, provided they were not so inconsiderate that they had symptoms attributable to dementia, and co-operated by getting well quickly. This approach would still leave us with the problem of the large number of old people at present in psychiatric hospitals. The Report quotes the usual figures, showing that there are 52,000 patients over the age of 65 in mental hospitals at the present time. Of these, 27,000 are over 75 years of age. Over the past 15 years, the number of in-patients of all ages in mental hospitals has decreased by 31 per cent. During the same period, the number of patients over 75 has increased by 50 per cent. The Department of Health and Social Security estimates that, on the basis of existing trends, almost two-thirds of the patients in mental illness hospitals might be aged 65 and over by the year 1980.

The Mind Report divides the elderly mentally ill into three groups, which they describe as:

(i) the mentally sick, which are those patients with functional disorders;

(ii) the graduates, who are patients that have grown old within the institution;

(iii) deteriorated patients, who have one or other type of dementia.

A number of important points are made about all three groups. Those with functional disorders may not be recognized as such on admission, and may be labelled as demented, and relegated to long-stay wards where their true condition may escape detection. Meanwhile their place in the community may be lost, and discharge from hospital, if they recover, becomes difficult, if not impossible. Large numbers of the graduate group could be successfully discharged from hospital if community services were adequate. Some hospitals and voluntary organizations have clearly demonstrated the feasibility of this, but their efforts have had little effect in general. Experience in parts of the country, where acute psychiatry is already moving from the old mental hospital to the general hospital unit, suggests that the mental hospitals are becoming under-staffed, neglected dumps for the elderly.

The Report goes on to ask 14 questions of the Department on its policy for the elderly. These include questions about research into problems and needs of old people, standards of medical and nursing staffing, conditions in long-stay wards, and the provision of services to support old people in the community, and whether geriatricians and psychiatrists have been appointed in each area to provide adequate services for this group of patients.

This is an important report. There is an urgent need for a clear statement of policy from the Department that will include the provision of an adequate comprehensive service for old people with psychiatric symptoms which will help both those with functional mental disorders, and the larger group, so easily labelled demented and ignored, that can in fact be helped and supported much more effectively and successfully than many appear to realize. These services need to be run by people interested in psychiatric illness in the elderly; whether they are called psychiatrists with a special interest in the elderly, or geriatricians with a special interest in mental illness is immaterial, provided such appointments are made. On the whole, it would appear more satisfactory if psychiatrists took on this role, and stopped pretending that the old were not their concern.

J. A. WHITEHEAD.

CORRESPONDENCE

'OPINION'

DEAR SIR,

The June issue of *News and Notes* begins with a paragraph entitled 'Opinion', but omits to reveal whose opinion the paragraph expresses. The implication is that it is the opinion of The Royal College of Psychiatrists. This of course it cannot be for (1) Fellows and Members of the Royal College vary considerably in the opinions they hold, and (2) no attempt has been made to seek their opinions on the matter discussed in the paragraph.

Certainly, as one member of the College, I do not

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agree with the opinions expressed. It is suggested by your anonymous contributor that the mass media misleadingly stress the significance of familial factors in mental illness. It is claimed (i) that the case for the familial aetiology of mental illness is presented in a one-sided and superficial manner, (ii) that this engenders guilt in the members of the families of psychiatric patients, and (iii) that it deters potential patients from seeking help. In my opinion the presentation of mental illness in terms of family dynamics is usually carefully and thoughtfully done by the mass media. The recent programme in the 'Spaces Between Words' series illustrating Esterson's version of family therapy is a case in point. It is perhaps not before time that members of patients' families were made to feel in some measure responsible for the predicament in which patients find themselves, for in many cases they are. Finally, far from discouraging patients from seeking psychiatric help, it is highly probable that presenting so called mental illness in a manner which reveals it as the outcome of intrafamilial conflicts is likely to make it more comprehensible and to reassure people that we in the psychiatric profession are not blind to those factors which seem all too obvious to the sensitive layman.

I should like to propose that the practice of expressing such anonymous opinions in *News and Notes* should cease. Discussion of topics of current interest is highly desirable, but we, like the mass media, should invite experts to present each side of the case fairly and comprehensively.

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DOCTORS, SAMARITANS AND SUICIDE

DEAR SIR,

My attention has been drawn to an article by Dr. Brian Barraclough in the April 1972 issue of *News and Notes* (1), which is critical of a study in which I investigated the effectiveness of Samaritans. This study (2) indicated that the introduction of Samaritan schemes was followed by a significant reduction in suicide rates, in comparison with demographically matched control towns in which such schemes did not operate.

Barraclough's first criticism concerns his feelings about whether some of the towns (experimental and control) are well-matched, and he suggests that some pairs of towns are unrealistically compared with one another. He is unsure, for example, of the wisdom of matching Hull and Merthyr Tydfil. Barraclough's objections to the matching are based purely on intuition, and since the basis of this intuition is not made clear I fear that it cannot be taken in any way seriously. The controls in the original study were drawn from the results (3) of a principal components analysis of 57 census-derived social and demographic variables for all towns in England and Wales. The control town was the most similar town (without Samaritans) to the experimental Samaritan town as indicated by the simultaneous plotting of four axes, representing the four major components of the data. A second set of controls was taken, this time matched with the experimental (Samaritan) towns on three demographic variables which are known to vary with suicide rates, namely age, sex and class structure. Using this fresh set of controls, the differences in suicide rate in the Samaritan and the control towns remained significant.

Recently the original study of Moser and Scott from which I drew controls has been criticized on technical grounds. Andrews (4) has proposed an alternative kind of analysis of Moser and Scott's original data, namely a cluster analysis rather than principal components analysis. This re-analysis identifies fourteen distinct clusters in a taxonomy which is significantly different from that presented by Moser and Scott. It appears that six of our original experimental towns could have more adequate controls than those chosen in the original study. The new controls are (Samaritan town first: control town second), Liverpool : Newcastle; Derby : Sheffield; Manchester : Oldham; Birmingham : Leeds; Swansea : Newport; Bradford : Dewsbury. Merthyr remains an adequate control for Hull! I have recalculated differences in suicide rates in the relevant periods, and the difference in favour of the Samaritan towns remains significant, at the 5 per cent level.

The second point which Barraclough makes is that there may be an intervening sociological variable, which caused both the decline in suicide rate and also enabled sufficient people to come forward and staff a Samaritan branch. But what can this mysterious sociological variable be? It could conceivably be an increase in social cohesion, which Durkheim has shown to be inversely correlated with suicide rates. But why should there have been an increase in social cohesion in Liverpool and not in Newcastle, and in Derby and not in Sheffield, for example? The reasons for this emergence of social cohesion are very obscure. It seems to me to be far more plausible that Samaritans were organized in a particular town because of situational factors, such as the existence of an enthusiastic priest (like Chad Varah) who possessed sufficient energy and influence to get a branch going.

The kind of sociological phenomenon which can influence suicide rates is well illustrated by Lyon's

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