data provides a good introduction to research (on a collaborative basis), especially since these can be presented fairly simply at a Society meeting. This provides a grounding for more formal projects which, however, may not be sufficiently thought through or discussed with the relevant disciplines. Projects may be set off without the slightest inquiry as to the availability of material (e.g. EEG records). On the other hand, investigatory data (such as EEG) may be largely ignored—or seldom made much of in a joint way.

All this contrasts with my experience in the States where collaborative work seems to begin at the student project stage. Moreover, when visiting a department one would be invited to hear junior staff expound on their projects and apparently would be welcome when going into problems over availability of material and times, etc. It would be interesting to know whether 'research in decline' applies to other countries—would a transcultural addendum be relevant?

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DEAR SIR,

While Dr Crammer has made some helpful comments on approaches to research, his other comments on the 'decline of research, by registrars (*Bulletin*, Nov 1979 p 174) must be questioned. If registrars 15 years ago thought an investigation or publication would help them to a consultant post, does a decline in research provide an index for the intellectual curiosity of each generation or only of their career-mindedness? If there is a decline, does it reflect the higher standards expected for publications (journals have increased, and presumably are maintained by more senior researchers, as the juniors are less active)? The decline in research may be bad, but does this indicate a decline in the will to better practice? The curiosity of registrars may well be in decline, or dulled by examination preparation, or overstimulated by rotational exposure to a variety of firms, settings and subspecialties, or may seek outlets in applying the various new therapies to clinical practice; who knows?

Encouragement to embark on an investigation is important, and may stem from some different assumptions about the subject. At a recent meeting of the Assocation of University Teachers of Psychiatry, Professor Gelder commented that 'some are temperamentally not suited to research'. His message seemed to have a paradoxical and coaxing element: people have different talents, there is no discredit in not succeeding, so why not try? That seems a good starting point.

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Mental Handicap—The National Development Group Report

DEAR SIR,

Professor Mittler, in defending the 1978 Report of his now defunct National Development Group (*Bulletin*, Dec 1979, p 195), asks how far Dr. Shapiro's criticisms in his review (*Bulletin*, Sept 1979, p 138) are shared by the majority of psychiatrists. It would be more apposite to ask how many psychiatrists supported the views of the Group? Professor Mittler rather pensively says that they did hope to have such support, but nothing to this effect has surfaced in the correspondence column of the *Bulletin* or in the other medical publications that I have seen. Drs Blake, Spencer and James (*Bulletin* Nov 1978, p 197) have, however, expressed great regret that the Group's associated team omitted the biological aspects of mental handicap, and the writer (*Bulletin*, Jan 1979, p 15) had questioned the excessive costs (so far unanswered) of the community units and teams proposed by the Group.

I would suggest that the NDG, and its team, has not achieved majority support by psychiatrists specializing in mental handicap, and in its Report (p 73) it acknowledges its disappointment at so little progress being made on the lines suggested by Mrs Barbara Castle in 1975. In fact its own philosophy (*Report* p 5) seemed to support the transfer of the hospital services out of the NHS altogether.

It should not be concluded, however, that the seeming lack of consultant enthusiasm for the NDG indicates a wish to return to the generally hidebound services of, say, 20 years ago. Evolution must take place, and some of the notions of the Group and its team are very sound; it is the style and exploitation of their execution that is at fault. Many of those consultants who did not seek early retirement or posts in other fields have been greatly disturbed by the disruption of services as abrasive revolutionary zeals have reached their zenith in the past year or so. It is now to be hoped that a formula for a more cooperative partnership, which will effectively incorporate psychiatrists and other specialists, can be found that will facilitate a better delivery of clinical services to the patient and his family, freed from the largely political trammels that presently absorb so much time and money.

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DEAR SIR,

I regret I cannot agree with Professor Mittler's contention that the Report of the National Development Group has not ignored the contribution of the specialist medical staff. The paragraph to which he refers (and surely it ought to be chapter 7 and not chapter 9 as given in his letter) deals with

consultant staffing levels and the function of the consultant in the community rather than his function in the hospital. In chapter 2 (entitled 'Aims of the Mental Handicap Hospital') the section devoted to the hospital as a source of specialist help (2.5) makes no specific mention of the role and the contribution of medical staff to patient care.

No-one reading the paragraph on epilepsy (6.4.4—page 65) could possibly imagine that the hospitals are staffed by specialist doctors who are always available and who, by the nature of their specialty, ought to be skilled in dealing with epilepsy in all its manifestations. Furthermore, the discussion on specialist needs (page 66) introduces a confusing dualism by allocating physical care of the handicapped patients to general practitioners. The fact that the mentally handicapped in hospital are referred to throughout the Report as 'residents' and not as 'patients' acquires an ominous connotation in the light of these omissions.

I cannot let go unchallenged the statement that 'We suspect that one of the factors contributing to the continued poor performance of some Regions in recruiting scarce specialist staff may be a reflection of an excessive hospital bias in the service as a whole'. My own conviction (and I have been recently involved fairly actively with the problems of recruitment of consultants) is that the situation is just the reverse. It is the attempt to destroy the large hospital and replace it by small units in the community in which good clinical work becomes almost impossible that makes the present service in mental handicap so unattractive to keen and interested clinicians. It cannot be denied that these small units are unable to provide the facilities that are necessary in modern hospitals for carrying out high quality clinical work; they are too small to create a stimulating living environment for patients and are almost impossible to staff adequately by specialists without inflating enormously the cost of care. Furthermore, senior staff responsible for a number of such diminutive units tend to spend more of their time in their cars than with patients. Recruitment is also affected negatively by the low morale existing in the specialty due to the continual attacks on the role of medicine not only by the voluntary bodies but also by the National Development Group and the DHSS. The concept of the multidisciplinary team is eroding the position of the consultant.

Again, in spite of Professor Mittler's protestations, problems of research do not appear to rate enough importance in the eyes of the Report to deserve even a subheading—to say nothing of a full chapter. The Report quotes, apparently with approval, Mrs Castle's statement that there is a 'yawning gulf between our knowledge of the possibilities of ameliorating mental handicap and what is done in practice' (7.13). I submit that our knowledge is grossly inadequate and that research, in both the biological and medical aspects as well as into the organization of care, is still badly needed.

Since my views tend to be misrepresented, may I make a short statement of them? I believe that the clinician's concern should be with the needs of the mentally handicapped rather than with their rights. These needs can only be established by investigation and research concerned with establishing facts and not slanted towards preconceived ideas of optimal modes of care. Once the needs are established, the type of service best suited to satisfy those needs can be formulated. These patterns of care should then be evaluated by careful pilot studies. I recognize that my belief that adult mentally handicapped people need the help of a supportive environment and the benefits of a wide area of social integration provided by a large hospital is not much more valid than others' belief in the benefit of community care. The acid test of the correctness of our theories is experiment founded on meticulous research methodology. If such an attitude were accepted, we would hear less of the quasi self-evident verities we find in the Jay Report and in the present Report, and less dogmatic statements of the benefits of community care and the disadvantages of institutionalization. It is continually forgotten that the Command Paper on 'Better Services for the Mentally Handicapped' made tentative suggestions and explicitly stated that considerable experimentation and research are necessary before final patterns of care are adopted.

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[This correspondence is now closed—Editor.]

The Worcester Development Project

DEAR SIR,

It is remarkably unfortunate that Dr Early (*Bulletin*, November 1979) takes such a negative view of the Report of the Symposium on Chronic Mental Illness (DHSS Worcester Development Project) and of the Worcester Project itself. Among other things he states that Dr Hassall 'did not consider the old long-stay patients nor those with cumulative chronicity'. This is incorrect. The patients described in Dr Hassall's paper were those on the case register who had become long-term since 1973. This, by definition, excludes the old long-stay, who represent in the main a very different group that is not being replaced. An example of the service use of a particular example of a patient falling into the category 'cumulative chronic' is shown on page 32 of the Report (Fig 11). The problems and importance of monitoring such cases are also considered in the last three paragraphs of page 26.

As Dr Early questions the statement that the complex network of services is almost complete, it must be put on record that apart from the two DGH units (in-patient and day hospital accommodation), the two local authority day