this merely raises further questions such as: what is it in the treatment programme that is essentially therapeutic for those individuals who do benefit?

We have made further studies in these areas, although some of our results are tentative and even a little confusing. One investigation I carried out in collaboration with Dr. Norman Macaskill involved reviewing the data of 254 consecutive admissions to the Day Hospital during the period 1969/71. This revealed results somewhat different from those of my original study (*Journal*, March 1973, *122*, 307) and no doubt implies some changes in our treatment regime generally. In summary, we showed that age, sex, marital status, social class, and intelligence did not appear to affect treatment outcome significantly. A wide variety of diagnostic categories were treated successfully, and results for schizophrenic disturbances and for patients with personality disorders compared favourably with those for other diagnostic categories (see Table). Referral following a suicidal attempt

TABLE
Diagnosis and outcome among 254 admissions

Category	Per cent patient population	Per cent treatment effective
Depressive neurosis	34	65
Manic-depressive psychosis ..	9	57
Anxiety neurosis	24	73
Schizophrenic disorder ..	3	63
Personality disorder	23	71
Alcoholism	2	60
Other	5	83
Overall	100	68

carried the poorest prognosis, but members of this group who benefited seemed to do best with family and/or individual therapy in conjunction with the standard treatment regime. Total duration of therapy emerged as a significant variable. Discharge at less than four weeks was associated with a poor outcome, and patients remaining in treatment for 9 to 16 weeks did best. Previous episodes of mental illness did not affect treatment outcome.

I suspect that findings such as these, which concern clinicians day by day, and the problems underlying them, will be illuminated not so much by large scale sophisticated studies as rather by the unremitting attention of a large number of modest investigators. Research is not an esoteric activity; but many psychiatrists are inhibited from evaluating their own clinical practice because of an absurd but well-fostered notion regarding what is 'scientific' or acceptable for publication. My colleagues and I continue to nibble away in our corner of the cabbage patch and may yet provide a butterfly or two.

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SERVICES IN THE COMMUNITY FOR THE MENTALLY ILL

DEAR SIR,

I agree with much of Dr. Burkitt's letter (*Journal*, July 1973, 131), but would like to go considerably further. There is increasing concern that the new District General Hospital Psychiatric Units will be inadequate to cope with the demands placed on them and that their introduction as a national policy has preceded sufficient evaluation (Wing, J. K., 1971; Fryers, T., 1973a, b).

As the target of 0·5 beds per 1,000 is approached, more and more of the burden of residential care will be placed on the non-hospital part of the service. Yet in so far as the former will continue to have as its priority the treatment of the acute psychiatric patients, resources will be concentrated on the hospital at the expense of the non-hospital service. A further limitation of hospital units is that their environment is anti-therapeutic in many ways for the majority of psychiatric patients, whose needs are quite different from those of the physically ill—though proper screening to exclude physical illness is of course important (Johnson, D. A. W., 1969).

I would therefore suggest a modification of the current policy: (1) that hospitals should continue to be responsible for the organically ill psychiatric patients; (2) that the non-hospital part of the service should take responsibility not only for the care but also for the *treatment* of the functionally ill. Many policy documents have stressed the need for a comprehensive and integrated system of care. To make an integrated community service requires hospital and non-hospital parts of the service to have equal status. Standards of care seem to be correlated with the degree to which patients are considered to be interesting to doctors. To draw the acute functionally ill patients into the non-hospital based service will draw doctors and other staff there; other resources will follow. Without such a change in emphasis, the so-called 'community' service will become in ten years the equivalent of the old back wards of the large mental hospitals.

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SUICIDE PREVENTION —MYTH OR MANDATE?

Dear Sir,

Britain is the only country in the Western world which has significantly reduced its suicide rate in the last 10 years. Both the Samaritans and psychiatrists have claimed credit for this. In my letter (1), I pointed out that deaths from most forms of suicide have, over the years, remained fairly constant, except for those caused by poisonous substances—mostly pills—which have gone up, and those caused by domestic gas poisoning which have fallen dramatically. The fall in the number of gas suicide deaths over this period has exceeded the fall in the total number of suicide deaths. Hence the fall in gas suicide deaths more than accounts for the fall in Britain's suicide deaths.

From 1963 onwards the Gas Council has steadily reduced the content of lethal carbon monoxide in its domestic gas. I drew what appears to me to be a reasonable conclusion: that the credit for Britain's falling suicide rate should go to the Gas Council rather than to the Samaritans or psychiatrists.

Dr. Bagley in this letter (2) disputes such a simple conclusion. He writes that if this were so there would have been, in the 1960s, an increase in 'failed suicides' by gas poisoning. He produces figures from a casualty department in Southern England of the ratios of failed gas poisoning to other forms of failed suicide. These ratios consistently fell—from 21·1 per cent in 1960 to 4·8 per cent in 1970. On the strength of these falling ratios he rather cryptically argues that 'the fall in the rate of completed suicide has been largely due to factors other than the detoxification of gas'. But:

(i) Gas made from coal contains carbon monoxide, but natural gas and the gas made from the new processes of 'oil gasification' do not. As new plant replaces old, domestic gas contains progressively less carbon monoxide. An extensive 'gas grid' connects the regions of Britain through which the gas is pumped according to demand. Thus in any one region gas may be lethal one day and harmless the next. Dr. Bagley is wrong in assuming that if domestic gas fails to kill a suicide attempter it will leave him ill instead. Inhalation of the new gas may leave him as healthy, if not as hearty, as ever.

(ii) The iatrogenic pastime of taking overdoses is increasing in Britain at the rate of about 10 per cent each year. Taking overdoses is much more common than 'sticking one's head in the gas oven', a method preferred only by the smaller number of the more serious-minded suicide attempters. The pill swallowers steadily and increasingly overshadow the gas inhalers, and this no doubt accounts for Dr. Bagley's falling ratios.

(iii) Dr. Bagley is of course, perfectly right when he says that 'the similarity of "two curves" on a graph does not demonstrate a causal trend.' But even in statistical analysis there may well be room for common sense.

When the annual rates of Britain's total suicides, suicides by gas poisoning, accidental deaths by gas poisoning, and the average yearly content of carbon monoxide in domestic gas are plotted alongside each other on a graph, all four curves are found to be similar. They took a deep plunge in 1963 and have continued to go downwards. During the years 1963–1970 total suicides fell from 5,639 to 3,940; suicide deaths from gas poisoning from 2,353 to 511; accidental gas poisoning from 1,246 to 270 (3); and the average annual carbon monoxide content of domestic gas from 11·6 per cent to 2·2 per cent.

It is, of course, perfectly legitimate to argue that there is no causal connection between the similarity of these curves—to argue, that the reduction in deaths due to accidental gas poisoning is not due to the reduction of carbon monoxide, but is, for instance, due to the improved psychiatric services. Gas taps are left on less often because the memories of the elderly have been improved, and gas pipes no longer leak because the workers, having been made content by antidepressives, maintain gas pipes in better repair. Personally I prefer the simpler explanation that deaths from accidental gas poisoning and from suicidal gas poisoning have both fallen because domestic gas, when inhaled, is now often no longer harmful.

The point of this letter is not to be beastly to the Samaritans or to psychiatrists. If there were evidence that suicide prevention programmes reduced the suicide rate it would certainly become mandatory upon us to establish more of these programmes. As yet there is no evidence to suggest that they in any way reduce the incidence of either suicide (4) or even of attempted suicide (5). This being so, it seems to me that we should spend our available money not on suicide prevention programmes but on other psychiatric services which may prove more useful.

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