examination of difficulties and the fact that the staff keep asking patients for suggestions about each other's needs, trains the individual patient for social maturation and develops the need to belong.

A good milieu also provides the right environment for specialised techniques, be they group or individual, to flourish. The discussion groups help in many ways, including prevention of jealousy about extra treatment given to one, or misunderstandings about why a patient is treated in a certain way, e.g. by being secluded. The groups also teach social cohesion; a common difficulty in the majority of psychiatric patients is difficulty in relating to others, they more frequently belonging to the 'out' group rather than the 'in' group. Psychiatric patients frequently tend to be egocentric, to be aware of their own difficulties rather than the difficulties of others; the social training of milieu therapy helps combat this. Although all this is relatively new in Britain, the kibbutz system in Israel shares many of its principles, as does traditional tribal life.

A small but important point in milieu therapy is the personal and educative help staff can get both from other staff and patients. This also means that staff have more time to treat (rather than just look after) patients; or perhaps the ward could run with fewer staff—patients are taught to share the responsibility for a difficult patient and not leave it all to the staff. Free communication results in patients alerting staff to the fact that a patient is threatening to abscond—this also helps teach a patient responsibility. As in life (e.g. divorce) frequent changes of staff (from any discipline) can be disruptive and harmful. Patients particularly need to learn to trust and gain stability from their surroundings.

Correspondence

The Health Advisory Service

DEAR SIRS

We write to protest about the methods of operation of the Health Advisory Service. We have been told that we must fully sectorise our service, and also that we must have special areas of consultant responsibility within our unit. We have four questions. First, does the HAS have objective evidence for its strongly held beliefs? (We doubt it.) Second, is it reasonable to impose these beliefs upon others who do not share them? Third, should it not be expected that advice should be adapted to local conditions? Finally, why is there no appeal procedure when an HAS Report contains advice which would lead to serious adverse effects on both our patients and those whom it is our responsibility to train?

We are proud of our service, which we have all worked very hard to create. (Indeed, even the visiting HAS team said how impressed they were by the dedication of our medical and nursing staff, and by the close collaboration between the University Department and the NHS teams.) We provide service in a district general hospital from five clinical teams to our small, densely-populated catchment area. Each team has some special interest in addition to taking general psychiatric admissions when they are on 'take', and our general practitioner colleagues are unanimous in wishing to preserve their freedom to refer an individual patient to the consultant of their choice. More important still—although less easy to document systematically—many of our patients have told us that they also value their freedom to choose a consultant. All this is to go: we are instructed to introduce rigid sectorisation.

All of us have had training in social psychiatry and our practice has been influenced by the finest social psychiatrists that this country has produced. They taught us to insist on continuity of care so that a patient is looked after by the same team irrespective of where she or he is in the hospital. This must cease! If we follow the advice laid down, a young woman who was referred to consultant A because she lived in Acacia Avenue, would be referred to consultant B for day hospital care, to consultant C for in-patient care for her puerperal illness, to consultant D when her disturbed behaviour necessitated treatment in our high dependency ward, and finally to consultant E for rehabilitation. We are, of course, fortunate to have so many consultants, but then we are a major teaching hospital. Our visiting consultant colleague does not work in a teaching hospital, and sought to impose the standards of a suburban London mental hospital on a service which has many vivid points of contrast to his own.

We do not think that our views are necessarily right, but we do think that we have a right to have them, and that if they are to be completely disrupted we should be presented with some evidence for the change. Where is this evidence? Without it, we would have no difficulty in ignoring the HAS advice. However, our district health authority lacks our knowledge and is bound to overvalue advice which they receive from the HAS.

Finally, how does one appeal? It is no use writing to the Director of the HAS, since he adopts a defensive posture and refuses either to withdraw the advice or to send a team to revisit us. Has anyone else had similar experiences? And, if they have, what should we be doing about it?

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