we wish as private individuals through other channels. It seemed certain that our professional colleagues in South Africa would suffer if the resolution were passed. As I recall, there was at the time considerable hasty and high-flown rhetoric both in favour of and against the resolution. I suspect, however, that those in favour had come better prepared with their arguments. I abstained because I felt I simply wanted more time to consider the issues knowing, as I have said, how influential such a College resolution might be.

I am now prepared to say that I would vote against the resolution and am in favour of it being rescinded. My conviction is that as psychiatrists and Members of the College, we are wise to be extremely clear-thinking with regard to our aims and motives when leaving the clinical and entering the political arena. Unless this is the case, and unless we are clear about the effects of our intervention, and unless those effects are uniformly beneficial, then we run the risk of exhausting ourselves and exasperating each other, diverting energy carelessly away from the most important everyday work we have embarked upon, to relieve the distress of those suffering from mental disorder at home.

In this endeavour we are often called upon to show considerable degrees of tolerance, understanding, patience and perseverence. These qualities have been known to have effect in political situations too where confrontation might only have prolonged and possibly intensified the misery. Why should we not set this kind of example for the world? Let wisdom guide.

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DEAR SIRS

I have read with fascination the correspondence from Dr S. Baumann (*Bulletin*, February 1988) and Professor Simpson (*Bulletin*, April 1988) and the replies from Dr Birley.

Dr Birley implies that it is incompatible to be from an "apartheid university" and to be standing out against political oppression. Firstly I am not at all sure what his phrase means. All universities in South Africa have to operate within the constraints of apartheid legislation which apart from being manifestly unjust is also very detailed. Nevertheless several universities in South Africa have a fine record of resisting apartheid with all the means available to them.

Secondly thousands of staff and students at these universities have over the years risked their liberty to fight apartheid. Many have been banned, jailed, or driven into exile; among them the President of one of the Royal Colleges. Their integrity and courage would stand out wherever they worked, and that includes Britain. We have much to learn from them and they deserve our support.

Let me give an example. A non-medical academic friend of mine recently received a British Council award to visit a British university. On arrival she was informed that she was not welcome because she came from South Africa. She had only recently been released from a harrowing period of detention without trial. When this came to light there were hasty apologies and retractions.

Perhaps the moral is that few people in Britain have a sufficiently detailed knowledge of South Africa to know how to help anti-apartheid South Africans. May I suggest that the College approach democratic South African organisations to ask them how they wish to be helped? Unsolicited assistance can appear patronising, even when well intended. On this occasion it has also been inept.

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Psychological aspects of nuclear war

DEAR SIRS

Hugh Middleton (*Bulletin*, May 1988, **12**, 203) draws attention to the book by Dr James Thompson, *Psychological Aspects of Nuclear War* published as a statement by this Society. He suggests that the College should 'guide public opinion' by setting up a body to review relevant research, agree policy and make opinions known.

We published the book in 1985 and there may well be new research to consider, but as a start point I would urge all interested parties to read Thompson's book (£7.95).

By the way it is The British Psychological Society, not Association.

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Hospital hostels and the Griffiths Report

DEAR SIRS

I recently attended one of the interesting conferences on 'Residential Needs for Severely Disabled Psychiatric Patients: The Case for Hospital Hostels' currently being held around the country. The meeting at which I was present, however, had difficulty in defining just what a *'hospital hostel'* was. I would like,

therefore, to offer a simple definition: A hospital hostel is a unit for the chronically mentally ill in which:

(1) the residents remain in-patients;
(2) the building is physically separate from the parent hospital;
(3) the daily programme places an emphasis on the performance of 'life skills' such as cooking, shopping and cleaning.

If criterion (2) is not met I suggest that the unit is a *hostel ward*, whereas if only (1) and (2) apply the facility is a *ward in the community*. Hospitals hostels, then, have been operating in the United Kingdom for over 25 years, but surprisingly no-one seems to know how many there are. It is my impression, however, that there are many more *quasi hospital hostels* in which the residents are discharged patients contributing their DHSS benefits to the funding of the hostel. In Oxford, for example, although we have only two hospital hostels, there are five hostels for the chronically mentally ill, heavily supported by Health Authority staff, run by the independent charity Oxford Group Homes Organization.

Although there may be some advantages in separating hostels from the more regressive aspects of hospital care, I believe the main motive for the development of 'quasi hospital hostels' has been financial. The demand-led nature of DHSS benefit-payments has in recent years permitted developments impossible for cash-limited and 'RAWped' Mental Health Units. Around Britain much time and ingenuity have been expended in setting up such hostels, but as the Audit Commission pointed out, the resultant complex arrangements are not necessarily the most cost-effective way of spending taxpayers' money.

Within Sir Roy Griffiths' Report, however, there is a suggestion which if followed would resolve many absurdities, whilst ensuring the quality of care currently being delivered by hospital hostels. Paragraph 6.12 states "The responsibilities of regional and district health authorities should in general continue to be the provision of health care. In broad terms this involves investigation, diagnosis, treatment and rehabilitation undertaken by a doctor or by other professional staff to whom a doctor . . . has referred the patient." This means to me that the "severely disabled psychiatric patient", "new long stay", or "young adult chronically mentally ill" should be recognised as requiring health care and treatment whilst living in their "ward", "hospital ward", "hospital hostel" or "staffed hostel", and that it is a Health Authority duty to provide the resources. If this recommendation was accepted one could then be confident that the best setting for any individual patient would be determined, as it should be, by clinical factors alone.

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Video of treatments in psychiatry

DEAR SIRS

I am endeavouring to produce a video for the use of paramedical staff in hospitals and the community to show commonly used treatments in psychiatry. This will include physical treatments, e.g. ECT, and psychological treatments, e.g. biofeedback, reality orientation. Subsequent editions may be planned for medical students and junior doctors new to psychiatry.

May I through the *Bulletin* enquire whether similar audio visual presentations have been made. Any help and information will be greatly appreciated.

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Alternatives to the mental hospital patient

DEAR SIRS

The May issue of the *Bulletin* reflects the growing concern and anxiety of many psychiatrists with their own (and in some instances with their patients') future.

Alternatives to the mental hospital are urgently canvassed and just as anxiously called into question.

I have a suggestion. Instead of thinking about alternatives to the mental hospital perhaps we should be thinking in terms of alternatives to the mental hospital patient.

It is a matter of horses for courses. Some psychiatrists are more adept at looking after certain sorts of patients than other patients with dissimilar troubles. For example, some would prefer young, educated, and articulate customers: and in this context it has often struck me that one suitably favoured patient could last a similarly endowed psychiatrist both their respective lives – this being more likely in the non-organic fields of psychiatry.

But how, I hear you ask, Mr Editors, can all this be brought about? Well, having regard to the prevailing political ideology of market forces it might be perfectly feasible (and I propose to patent this idea, so don't let anyone try and jump in on the act) to set up a Central Agency which would endeavour to match particular patients to particular psychiatrists (the idea has, of course, worked quite well in other areas of human endeavour).

Interested parties could then apply to the Central Agency, stating their preferences. One anticipates that there would be a greater demand from some psychiatrists for upwardly mobile psychotherapeutically inclined executives with the burn-out syndrome than for, say, more chronic forms of dementia.