It would be a simple and useful check if some Muckamore patients could be re-rated using Wessex scoring methods to see how comparable the residents really are. Until this has been checked, the conclusion must be in doubt that Muckamore Abbey in-patients (let alone Northern Ireland in-patients) have more disabilities than in-patients in the Wessex Region.

Criteria of Selection for Hostel or Hospital

The criterion for where a person should be 'treated' or 'cared for' depends entirely on his needs and those of his family, and where these can most easily and agreeably be met.

Our original division was *not* into the need for 'hostel' as opposed to 'hospital' care. It attempted to quantify the maximum numbers needing continuous 'medical' and 'nursing' care as well as 'residential care' and the minimum numbers needing *only* 'residential care' (4).

We have, however, always maintained that there is only one scientifically valid method of testing the hypotheses that 'people who are predicted to benefit from care in a locally-based residential unit will indeed do so,' and that 'persons who are predicted *not* to benefit from care in a locally-based residential unit will do poorly in such units'. This method is the experimental method.

Without experiment, the hypothesis cannot, by definition, ever be tested. Untestable hypotheses have not been particularly useful in the development of science.

In the Wessex experimental areas we are relocating *all* children from existing hospitals in locally-based units serving only these areas (5). So far, only one child out of 40 from a total population of 200,000 could not be so re-located. No child has so far had to be removed, and if the need arises, the reasons for so doing and the subsequent method of care made available will be documented in some detail. It is most important that someone undertakes a similar experiment to test the hypothesis that *all* SSN adults can be relocated in locally based units serving a population of about 50,000 and can be adequately cared for in such units.

Conclusion

The results of the Northern Ireland survey are of great interest. While there is every reason why they should differ very considerably from those found in Wessex and elsewhere in the U.K., the surprising finding is their similarity to other findings.

The main differences are a very much higher ascertained prevalence of SSN people in general. However, much the most interesting phenomenon which needs some explanation is the sudden rise in ascertained prevalence between ages 10–14 and up to 30–39 years.

Despite the higher total prevalence in Northern Ireland, the number of in-patients measured in rates per 100,000 total population for children, SSN adults and MSN adults is remarkably similar to that found in Wessex.

A detailed comparison of the incapacities of 814 Muckamore Abbey in patients appears to show some differences (more dependent) compared with those found among Wessex patients. Some evidence suggests that these differences may be more apparent than real, and arise from different use of category scores. This can easily be checked.

There is no substitute for local epidemiological surveys to assess local needs. Differences found in this way are also likely, if real, to throw light on new aetiological factors. The precise standardization of criteria of incapacity used in different studies would be helpful in making accurate comparisons.

ALBERT KUSHLICK.
Director of Research in Mental Subnormality,
Wessex Regional Hospital Board,
Highcroft, Romsey Road,
Winchester, Hants.

REFERENCES

1. DRILLIEN, C. M., JAMESON, S., and WILKINSON, E. M. (1966). 'Studies on mental handicap, Part I: Prevalence and distribution by clinical type and severity of defect.' *Arch. Dis. Childh.*, **41**, 528.
2. KUSHLICK, A., and COX, G. R. (1967). 'Ascertained prevalence of mental subnormality in the Wessex Region on 1st July, 1963.' Paper read at Montpellier Conference on the Scientific Study of Mental Retardation.
3. SCALLY, B. G., and MACKAY, D. N. 'Residential Care for the mentally subnormal (Muckamore Abbey). Report of a Survey.' Draft Copy.
4. KUSHLICK, A. (1969). 'Care of the mentally subnormal.' *Lancet*, 1196–7.
5. —— (1967). 'The Wessex experiment. Comprehensive care for the mentally subnormal.' *Brit. Hosp. J. and Soc. Serv. Rev.*, 6th October.

THE N.A.M.H. 'GUIDELINES'

DEAR SIR,

Up to now only two Members—and no Affiliates—have responded to the President's call for a wide-ranging discussion of this document.

I wonder if many feel as I do—namely that as far as nurses on the ward are concerned the 'Guidelines' will be of very little value. As a member of the General Nursing Council who helped to draw up the Mental and Mental Deficiency nursing syllabuses,

and as Chairman of the relevant Board of Examiners, both for a good many years, I know that candidates were expected to be able to discuss the causes of violence and the management of possibly violent patients; and moreover, the many thoughtful and intelligent answers to questions set on the subject showed that on the whole it was being adequately taught and understood. All textbooks on mental nursing have something to say about violence—perhaps the best discussion is that in Miss Altschule's *Aids*, which has been in widespread use.

It is hard to see how any nurses who have forgotten the instruction they have received, or who choose to ignore it, or who find it impossible to apply it in practice because of adverse circumstances, are going to be put back on the right road by the two or three paragraphs of the 'Guidelines' which are meant for them. These paragraphs are not even up to the standard of a nursing examination answer; for example, no distinction is made between the aimlessly violent low-grade defective, the unruly psychopathic girl, or the patient who is violent only because he comes from a milieu where violence is normal.

To put it briefly, good nurses do not need to be told what is in the Guide, and bad nurses will ignore it.

The 'Guidelines' are stated to have been drawn up in response to 'appeals from within the nursing profession', and more specifically to a letter addressed to the Committee of Enquiry into conditions at Farleigh Hospital by a group of nurses at that hospital. This letter purported to express the staff's anxieties and perplexities, but these related solely to the 'restraint' of violent patients. One wonders whether such a limited view of the problem could not have been dealt with more effectively by discussion on the spot—indeed it may have been—and whether it really called for the ponderous production of a code of almost equally limited scope. We all know that complaints at other hospitals have referred to old people who are not violent at all, but exceedingly trying to the patience of those attending to them; surely it is not intended that there should be a separate set of 'Guidelines' for these, and more for other types of patients? And if a really comprehensive code dealing with every eventuality is compiled by the proposed Joint Working Party, will not its scope not be co-extensive with the whole of psychiatric nursing, so as to be in effect just another textbook?

I should add that much of what is said in the paragraphs on administrative procedures is to be commended, though even here there is a certain amount of woolliness. If indeed there are any nurses who are prone to act 'other than in good faith' or to 'apply undue force' they will not refrain from such actions just because a patient's admission has been 'discussed with the Nursing Services'. The idea of policy being decided 'by discussion' (instead of 'after discussion') reflects the fashionable 'medical abdicationism'. Neither Conolly's 'non-restraint' nor T. P. Rees's 'open doors' could ever have been brought into being in this way.

ALEXANDER WALK.

18 Sun Lane,
Harpenden,
Herts.

MECHANISM AND MEANING

DEAR SIR,

Dr. O. T. Phillipson's strictures (*Journal*, March 1971 pp. 377–8) on my Ernest Jones Lecture, an abbreviated version of which was published in the *Journal* recently (Hill, 1970), call for a reply. He quotes two passages of mine (although the second contained a reference from a paper by Mr. H. J. Home which he did not acknowledge) to elucidate what he thinks I mean by 'meaning'. He reaches the conclusion that what I am 'concerned with are questions which are outside the scope of scientific explanation, that is philosophy, metaphysics or what you will'. Dr. Phillipson then states that the difference I have described between mechanism and meaning is the 'difference between the objectivity of science (insofar as that is possible) and the subjectivity of metaphysical speculation'.

If I had believed in such a simple conclusion, I would not have undertaken the task of writing the lecture, which was an attempt to discuss again the position of psychoanalysis and its claims to be a deterministic science—but to do so in the context of different types of conceptual model. Having ignored my arguments Dr. Phillipson has made his own interpretation of the posi ion, which is certainly not mine, and has then surprisingly stated: 'if this interpretation is correct, it shows a logical misunderstanding of psychoanalytical theory'.

There is only one other matter of fact in Dr. Phillipson's letter to which I wish to respond. He seems disturbed by my statement that for psychiatrists neither knowledge of how things happen in the nervous system, nor the full analysis of the outward forms of behaviour, if both were possible, will be *sufficient* for their purposes. This is a self-evident truth to most psychiatrists with any degree of clinical experience, but they would agree with Dr. Phillipson that knowledge of the nervous system and the analysis of behaviour are greatly to be desired, and that these 'approaches are essential'. But I think Dr. Phillipson has fallen into the common

https://doi.org/10.1192/bjp.119.550.347 Published online by Cambridge University Press