stopped abruptly due to the development of acute blood dyscrasia (red alert). We would recommend that the clinician should be aware of the phenomenon and generally wean Clozaril off patients not responding to long-term therapy.

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Cognitive therapy and Winnie-the-Pooh

DEAR SIRS

Hosty (*Psychiatric Bulletin*, **16**, 758) again illustrates that literary figures lead psychiatrists in observing and recording psychological phenomena. Winnie the Pooh provides not only a paradigm for cognitive and psycho-analytic models but a powerful therapeutic tool in himself.

N was an 11-year-old girl whose hysterical blindness led to her being admitted after which she deteriorated into a state of "pervasive refusal" (Lask *et al*, 1991) characterised by ceasing to walk, eat or drink, so that she had to be fed by nasogastric tube as she lay inert on her bed. Her Eeyorian propensity to predict the worst, and make the staff believe it, ensured maximum anxiety, and there was no Christopher Robin to make things better. Amid intense care, individual psychotherapy continued. Reflecting on her silence led to the therapist being deafened by the overwhelming power of her communication and he turned in desperation to childhood comfort and read *Winnie the Pooh* and *The House at Pooh Corner* to her.

Any notion of a therapeutic plan would be a retrospective falsification. The adventures of Pooh continued commensurate with the adventures of the team as they cared for N by organising visiting, getting into tight places, hunting for aetiological Heffalumps, chasing after meaning and getting lost in psychodynamic forests, with the resultant emotions of anxiety, feeling lost, despondency and dependency. The search for the North Pole became the psychotherapeutic route to recovery which came in anti-climatic fashion.

"Pooh's found the North Pole," said Christopher Robin
"Isn't that lovely?"
"Is that it?" said Eeyore.
"Yes" said Christopher Robin.
"Is that what we were looking for?"
"Yes" said Pooh.
"Oh!" said Eeyore. "Well anyhow – it didn't rain."

N slowly regained her interest in living as if Pooh's explorations had given her a secure base on which to continue to develop, and forcing us to reconsider whether Eeyore had a macabre sense of humour in his sense of self.

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"Death of a hospital"

DEAR SIRS

With regard to Drs Piezchniak and Murphy's report on the "death of a hospital" and the subsequent mourning ritual, attempting to compare this to the death of an individual (*Psychiatric Bulletin*, 1992, **16**, 482–483), this analogy is not appropriate and simply obscures the concerns many people have about the future for psychiatric patients. Too often when we read about such closures, people's reactions are attributed to an underlying "emotional" problem, rather than to their realistic fears for the future. We read about "the sense of loss" the "emotional attachment", "bereavement", and more critically, "anxiety about change". Thus, anyone who dares to suggest that such new "developments" are anything but good is deemed to have problems coping with change, and emotional difficulties which prevent them appreciating the value of such changes. The view that mentally disturbed people might find a therapeutic environment as soothing as a two-weekly injection from a visiting nurse is dismissed as sentimental and irrelevant.

Piezchniak and Murphy note that "it was evident that ... there was concern about the future". This should hardly be surprising, in view of the scale and speed of change, the lack of provision for the mentally ill, and the underlying trend for successive governments to disown responsiblity for mental illness, with which we as a profession are passively colluding.

Psychiatry has long-standing problems with image and creditibility, and things are not improving. Although there are treatments which are certainly more effective than those of 50 years ago, the same

cannot necessarily be said for our "care". While we are convinced that modern psychiatry is doing a splendid job, the general public, viewing the increasing mass of homeless mentally ill patients, and those incarcerated in prison, take this as visible evidence of failure. Such opinions, of course, are born out of ignorance, but in these days of market forces, can we ignore them? At least we must take people seriously and avoid the use of interpretive psychotherapy as a smoke screen.

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The College

1993 Trainees' Forum 'The Mental Health of the Nation'*

DAVID CASTLE, Honorary Secretary, CTC; and ROGER BULLOCK, CTC representative for Chiltern and Thames Valley

The setting of targets for health has the advantages of heightening awareness, focusing minds, and, it is hoped, ensuring availability of funding. The first of the targets in the medical health section of the recent government white paper *The Health of the Nation* (Department of Health, 1992), "to improve significantly the health and social functioning of mentally ill people", has none of the advantages of specificity or focus. Thus, the only true targets relate to suicide. Specifically, the aims are: (a) "to reduce the overall suicide rate by at least 15% by the year 2000" (b) "to reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000".

Dr Kingdon, senior medical officer at the Department of Health, gave some indications of specific strategies which could reduce suicide rates. The identification of those at risk, through education of GPs, or the introduction of screening for depression in general practice, is one area of possible intervention. Another is removal of the means; for example, by putting methionine in paracetamol tablets, and changing the shape of exhaust pipes to make carbon monoxide poisoning more difficult. Of course, any measures to reduce suicide rates are welcome, although if broader social issues such as unemployment (which engenders depression and despair) are not addressed, it is debatable how successful these specific measures can be.

Mr G. Henderson, a hospital manager from South West Thames Regional Health Authority, gave the Forum a managerial perspective on how the white paper targets could be met. Strategies mentioned included the establishment of integrated hospital/community/primary care services, setting explicit priorities, development and maintenance of local alliances; involvement of users and carers, the development of budgetary responsibility, and reduction in bureaucracy.

Professor Sims, introducing the College's response to the mental health component of *Health of the Nation*, welcomed the introduction of targets relating to suicide, and hoped that these could be met. However, the College document *The Mental Health of the Nation* (Royal College of Psychiatrists, 1992) makes clear that the College considers targets for suicide alone are not sufficient, and gives details of far broader targets (e.g. organisation of clinical services, requirements for in-patient beds, and consultant manpower) which need to be met to ensure that mental health can be effectively delivered in the future.

The impression from the Forum was that the approaches of the College and the Department of Health to mental health are very different. Indeed, while attempts to reduce suicide rates are laudable, the broader issues addressed by the College in its report must be taken into consideration if there is to be a true commitment to improving the mental health of the nation.

**Held at the Winter Quarterly Meeting of the College, London, January 1993.*

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