The mental health problems are acute psychosis, epilepsy, drug dependence, depression, and mental subnormality; the place is Pakistan. An enormous expansion has occurred since the services were first described on these pages:[1] medical officers have now been trained from every province in the country, and the school programme has spread across the nation and is carried forward by the teachers themselves—who have formed the All-Pakistan Teachers Movement for Mental Health.[2] The genie is out of the lamp, and will never go back inside.

Although the school programme has had a deep impact on the basic health units (BHUs) that serve each village, the reason that it will continue lies in the effects it has had on the schools themselves. While the former is of great interest to doctors in public health, the latter are surely of great interest to psychiatrists. As might be expected, the BHUs experience a great increase in referrals of patients with mental health troubles after the campaign opens in each school, but this increase should be seen in a context of a twofold increase in referrals for general medical care. The paradox is complete: psychiatry has made general medicine respectable. If psychosis and depression can be treated medically, then maybe haemorrhoids and jaundice can be as well. And as more village women come to the BHUs for childbirth, the programme may be expected to achieve the primary prevention of many cases of subnormality and epilepsy.

None of this accounts for the enthusiasm for the programme which seems to affect teachers and pupils equally. The teachers say that they feel closer to the children and now know more about them as people; some even claim that the children are dressing with more care and achieving better grades. The children are perhaps excited by their role as active participants in the programme, instead of their usual passive role. The certainly vote with their feet, since absenteeism is down by as much as 50% in some schools. They devote enormous energy to the preparation of wall-charts and posters, and see to it that every letter posted in the village is stamped with a mental health slogan.

Collaboration between religious healers and psychiatrists is not a new idea in developing countries. What is original to Pakistan is that these healers are issued with the same coloured case-identification cards as are used by the multipurpose health workers. One healer said that, although he thought that his results with hysteria were better than those obtained by the BHU, he had never done well with epilepsy or drug dependence, and was pleased to have his religious help for these patients supplemented by medication from the BHUs. Orthodox psychiatrists often object that working with faith-healers gives the healers a legitimacy that they do not deserve; but if enough patients receive treatment who would not otherwise have done so, the price is surely worth paying.

Developments in Pakistan should be seen in the wider context of provision of mental health services based in primary care in a part of the world not usually noted for medical innovation. The leadership provided by the East Mediterranean Regional Office of WHO has allowed the countries of the region to coordinate their efforts. Pakistan may have taken the lead, but Democratic Yemen, Yemen, Afghanistan, and Iran are not far behind. Moslem may not speak to Hindu, but a movement that began in India[2] has entered the Islamic world, and has even been improved by it.

When rehabilitation schemes for those with chronic psychoses also derive their power from the people, community psychiatry will have crossed its last frontier. The crossing may yet be made in Pakistan.

University of Manchester DAVID GOLDBERG

1. **Pakistan: revolution in mental health care.** *Lancet* 1987; i: 736.
2. **Wig N, Murthy S, Harding T.** A model for rural psychiatric services. *Indian J Psychiatry* 1981; 23: 275–80.

In England Now

AUTUMN; the season of mists and mellow fruitfulness; of evenings drawing in and clocks going back; of Heathrow closed owing to fog; and of that peculiarly British phenomenon, the evening class, for which a quarter of a million Londoners register every year.

But what to choose? London must surely be the evening-class capital of the world; and this year the soon-to-be-abolished Inner London Education Authority has provided a cornucopia rich in choice.

Languages are the staple of all evening classes. But not here just the French, Spanish, Greek, and Italian for next year's package holiday; and not here only the languages of the European Community (the provision for which would put the future national curriculum to shame). For those searching for their roots there are Cornish and Gaelic, and for the more exotically minded there are Amharic, Catalan, Euskera, Farsi, Ibo, Kweyol, Patwa, Putonghua, Romany, Somali, Sylheti, Tigrinya, Twi, Yiddish, Yoruba, and Zulu. And if academic linguistics doesn't appeal, then try French through Cooking or Cultural German.

Music also gets a broad range—everything from Introductory Bagpipes (mercifuly conducted on the top floor of a disused school), through Bamboo Pipes (Including Making), Gamelan, Gregorian Chant and Lute, to Sitar and Steel Band.

Some of the courses are immensely practical, although Woodworking for Beekeepers hardly fits any stereotype of modern inner-city life. Some courses are clearly to be taken in pairs: thus Christmas Cookery Preparation would be nicely complemented by the Workshop on Christmas Stress. Perhaps the only course in which a high drop-out rate may be regarded as a mark of success rather than failure is the one entitled Preparing for your own Death.

So what did I enrol for? Well, Introduction to Painting and Drawing was full, and so I was sent along to Life Drawing for Beginners. Explaining the receipt marked "model" was a bit difficult, and the first evening was reminiscent of that dreadful first day in the dissecting room, twenty years ago—flesh everywhere but armed now only with a piece of charcoal instead of a scalpel. But at last the anatomy is coming in useful, as they always said it would.

* * *

WHEN I was a medical administrator I felt the need to keep my clinical hand in, so I did holiday locums in general practice. These locums were of an unusual type. My approach was to write to a single-handed doctor in the Scottish Highlands and offer him a free holiday for a week or two. Free? Yes, I accepted expenses but took no pay. That way, both sides avoided the attentions of the taxman. The Highland doctors mostly jumped at the chance.

There was one practice that covered two of the Shetland Isles, which had an extraordinarily foreign atmosphere. The isolation made the work demanding, but it also made it satisfying. The worst feature was the journey to the second island—fortunately it was a small island and required few visits—because it meant eight hair-raising miles in an open boat through rough seas. The main reason for the infrequency of the calls was that the resident nurse had previously been stationed in Labrador and so could cope with practically everything. She thus matched the doctor, who was not only highly competent but also greatly loved by all his patients. There was no reason to vary any of his treatments.

During a locum in the Western Isles I found that the health of many of the patients was sometimes better than that of the doctor I was replacing, who had been too fond of the whisky for too long. He was another who was popular, but for a different reason; he had a good number of his patients on whisky as therapy. So here there was perhaps need to vary my host's treatment, but I did not. What I did was to polish the wording of my First Law of Locum-tenancy, which states that you must in no way contradict a doctor who cannot answer back. To do so can only mar his status with his patients, and it can do you no good. You will soon be gone; you have no status at all.

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