therapies. Moreover rotational training schemes require that trainees are pitched into a new job every six months which certainly discourages application to any therapy which is likely to require more than an hour or so a week for a few weeks. A further problem with psychological treatments is the fact that many anxiety states, mild depressive states, and obsessional disorders respond rather well to antidepressant drugs and a trainee may be discouraged from persistence with a psychological approach if all along he suspects that the patient may show much greater benefit from such prescription.

Cognitive behavioural treatments, although relatively brief in comparison with psychodynamic approaches, do require further abbreviation if they are to be widely applied to the prevalent problem of anxiety. I realised this fact when, as a trainee myself, I worked in a neurosis treatment unit. It became apparent that the huge problem could only be effectively tackled if self-help methods were developed.

It has been my major effort, both as clinician and trainee of junior psychiatrists, to develop such an approach and the method of Anxiety Control Training has been described in detail in my text, *Clinical Neurosis* (1991). It is a technique which requires only two hours of therapist time per patient (six to eight weekly 15-minute sessions) and it is readily taught to others. My experience over many years of practice has been that trainees rapidly acquire competence after brief instruction and from the very first year of entry into training have the satisfaction of applying a brief psychological treatment which, if selection is correct, may be rapidly effective. Long-term follow-up study of the outcome of ACT has been delayed by the problem of securing research assistance for the requisite period but this has now been completed and the study submitted for publication. We have shown that patients continue to improve with regular practice of the technique following the brief intervention by the therapist. This information provides the basis for an optimistic statement by the trainee who, on departure for the next post on rotation, may not see the patient again.

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Reference

SNAITH, PHILIP (1991) *Clinical Neurosis* (2nd edition). Oxford: Oxford University Press.

Psychiatrists as managers

DEAR SIRS

Dr Stern's suggestion that psychiatrists who become involved with management do so because of "poor therapeutic skills" (Psychological treatments by psychiatrists? *Psychiatric Bulletin,* May 1991, **15,** 296) is a surprising generalisation, especially given Dr Stern's commitment to cognitive therapy!

Effective management depends not only on a sound grasp of the new NHS business ethic, but also on the ability to understand individual and group dynamics and the capacity to work effectively with teams. These skills are the bread and butter of good psychiatric practice, hence good psychiatrists are often good managers.

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DEAR SIRS

The letter from Dr Power-Smith in response to my previous letter in the *Bulletin* somewhat misses the point. I do not mean to imply that psychiatrists do not often make good managers, but rather to emphasise that our training in therapeutic skills ought to keep up with current developments. Unless this happens, psychiatrists would not be well equipped to carry out psychological treatments.

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Cost-benefit analyses of psychotherapeutic treatments

DEAR SIRS

Uncontrolled studies of group-analytic therapy, inpatient psychodynamic psychotherapy and behaviour therapy have demonstrated a post-treatment reduction in health service usage and improvements in measures of economic productivity. Studies of clinical psychology attachments to general practice have demonstrated similar findings.

Unfortunately there have been only two controlled studies of note in this country. A study of behaviour therapy for phobias and sexual problems (Ginsberg *et al*, 1984) confirmed the earlier uncontrolled findings from the same unit, although attrition rates were high despite a follow-up period of only one year. A more naturalistic controlled study of a clinical psychology attachment to general practice (Earll & Kincey, 1982) found no economic benefit, contradicting the uncontrolled work.

Work from the United States suggests that psychotherapy is broadly cost-effective, leading to lower utilisation of other health services, particularly for hospitalised patients in older age groups. But much of these data come from insurance company records and therefore have limitations. Firstly, the health insurance system works to limit the number of

visits that can be made within a certain time period in a particular specialty; therefore, if patients go elsewhere for their treatment or have continuing unmet health needs, there is no way of quantifying (and therefore costing) this. Secondly, the open access of patients to specialist services tends to exaggerate any excess costs that are incurred. In this country, general practitioners act as a gateway to specialist care, limit its inappropriate use and, it is hoped, deal with minor psychiatric morbidity in a more cost-effective way.

More than ever before we are being asked to prioritise and choose between competing health care needs. It is therefore important to be able to justify the allocation of resources to treatment modalities that are expensive in their use of professional time for illnesses that generally speaking are in the mild-moderate range of severity. Notwithstanding this, non-psychotic mental illness produces its own economic burden on the community (Wilkinson, 1989).

If its treatment is cost-effective as well as clinically effective, there is a case for expanding resource allocation to psychotherapy services. Only further controlled cost-benefit studies of specific psychotherapeutic treatments can solve the problem satisfactorily.

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References

EARLL, L. & KINCEY, J. (1982) Clinical psychology in general practice: A controlled trial evaluation. *Journal of the Royal College of General Practitioners*, **34**, 377–380.

GINSBERG, G., MARKS, I. & WATERS, H. (1984) Cost-benefit analysis of a controlled trial of nurse therapy for neuroses in primary care. *Psychological Medicine*, **14**, 683–690.

WILKINSON, G. (1989) Estimated costs of neurotic disorder in UK general practice 1985. *Psychological Medicine*, **19**, 549–558.

A full list of references is available from Dr Mallett.

A very dangerous practice

DEAR SIRS

Every psychiatrist who has assessed mentally abnormal offenders remanded in prison will be aware of one glaring fact: that absolutely no information is available about the offence.

In fact, the Courts do not pass on any information even to the Prison Medical Officers. All that they have, and all that the psychiatrist has access to, is the offender's own account of the offence.

What tends to happen is that the offender, his mental illness notwithstanding – or because of the mental disorder – gives a watered down account of the offence, and claims that he is not in touch with any relatives. It is only after his admission to an open ward for assessment for reports that the true extent of his dangerousness became evident – when relatives telephone the ward to explain that the offender had tried to kill someone who lives down the road from the hospital, and that the threat was still being made.

On two occasions, though it must have been obvious from my report that the offender lied to the psychiatrist, the Courts went ahead and made an order to remand the offender to hospital for reports or treatment, and even completed a Hospital Order. My attempts to obtain an explanation from the Courts of their refusal to give some information to the Prison Medical Service about the offences committed by the inmates have been unsuccessful.

I would like to suggest that the College, especially its Forensic Psychiatry Specialist Section, look into this matter, and perhaps try to reach a compromise position with the Courts, to ensure that the assessing psychiatrist is made aware of the offence prior to the assessment in prison; failing which an incorrectly informed psychiatric report – one whose content reveals a serious disparity between the offender's account of his offence and what the Court knows – should not be a basis for a disposal to hospital.

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DEAR SIRS

Dr Azuonye has criticised the unwillingness of Courts to share information with psychiatrists considering patients for admission, or with prison medical officers. Sir Donald Acheson, the Chief Medical Officer, made some of his considerable reputation through his Oxford Record Linkage Study, in which he showed the gains to patients from linking up the many scattered records about them. However, in the case of remand prisoners, it is important that such linkage does not prejudice their chance of a fair trial, and for instance a magistrate who considers a defendant's suitability for bail, and so studies his previous criminal record, is automatically barred from trying the case. This may explain why Courts sometimes seem reluctant to release information, although bureaucratic inertia may not help.

There is usually little problem in obtaining background information in serious Crown Court cases. If the Court requests a report, copies of the depositions (the prosecution evidence in the case) are often supplied automatically, or can be obtained on request, particularly with the reminder that the Lord Chief Justice ruled some years ago that psychiatrists preparing court reports were entitled to see the