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Reviews

Pattern of Hospital Medical Staffing: Overview (1991. Pp. 42. £5.60) and **General Psychiatry** (1991. Pp. 68. £9.30). By Robin Dowie. British Postgraduate Medical Federation. London: HMSO.

In spite of the rather unprepossessing title, Robin Dowie's reports make interesting reading. It is illuminating to find out what colleagues in other branches of medicine or other parts of the country are doing. This made me alternately think more critically about my own work and count my blessings. Many senior colleagues work very hard in difficult circumstances without adequate support staff, without facilities and without junior doctors. Junior doctors work relentless hours particularly in the acute specialities. They work in very stressful and often uncomfortable circumstances. Almost every service is stretched and some beyond reasonable limits. I was struck again, that, despite doctors' image of arrogance, they are a dedicated and conscientious group of workers.

Dowie's objective was to consider the advantages and disadvantages of alternative patterns of medical staffing in the medical service and eight specialities in particular. General Psychiatry was one of these. The field work was done in five health districts in different regions during 1987 and early 1988. The reports were drafted in 1990–1991. One wonders how much more demoralised he would find doctors now and how the prospect or actuality of Trust status has affected them.

In spite of differences in clinical practice in different specialities, the demands made on all consultants are increasing. The greatest increase is in the clinician's role in resource management and in clinical directorates. Professor Harry Keen describes spending at least three sessions on management work as a clinical director of medicine at Guy's. This is a prospect that makes many active clinicians blanch. Clinical tutors too are increasingly expected to contribute more significantly to training. In some specialities, consultants still work a rigorous on-call system. It is easy to write a job plan of 15 sessions for many consultants. This report makes many useful suggestions; let us hope it is possible to implement them, particularly that medical assistance is available to cover consultant absence on other tasks. As we write our business plans with cost improvements of 1% per annum it is hard to see from whose pocket additional help will come.

The data on junior medical staffing indicate that doctors in hard pressed posts will have their hours reduced to 72 per week by 31 December 1994; in less hard-pressed posts by 31 December 1996. Even to achieve this there will have to be substantial changes in covering out of hours work. Again, more doctors will be needed. The report does not even address the endless non-medical tasks of junior doctors although this information has been collected. From April 1991, regional post graduate deans will hold a budget for study leave and this may be managed by clinical tutors day to day. Perhaps there will then be more equity in the quality of training offered juniors. Proposals are made for GP experience for pre-registration doctors.

The report on General Psychiatry is, of course, of particular interest. Looking across the country, the ability of health districts to implement plans for separate adult mentally infirm (AMI) and elderly mentally infirm (EMI) services is very different. (The report does not address other important specialisms; child, forensic, learning difficulties etc.) The two teaching districts had succeeded although not in terms of community care. The two non-teaching districts had introduced a similar structure but in both there were two EMI posts but only one filled. In the fifth district there was still only one EMI consultant for two health districts and the general adult psychiatrists carried much of the EMI workload. This is a subject dear to my heart – the lack of consultant old age psychiatrists is not in fact confined to non-teaching districts. To ask old age psychiatrists in post, who are often already doing two people's work, to commit even more time to management means services will suffer. Having read the whole report, I was grateful that administrators attached to consultant teams could lift some of that burden.

This report stresses the importance of psychiatry in general practice and recommends that it is a more common part of vocational training schemes. Sadly, it does not suggest a way in which other hospital doctors could gain some psychiatric experience. GP trainees could certainly fill more SHO posts and not use the career registrar posts which are restricted by quota. Much more work needs to be done to identify doctors who are stuck in junior grades. This might help in determining how many staff grade posts should be developed. I would like to see those individuals counselled earlier in their careers and given advice to prevent the complete demoralisation that can occur which is detrimental to whole services as well as individuals.

There is more in this report – particularly interesting observations on practice related to the Mental

Health Act 1983 and on the strong correlation between social deprivation and psychiatric admissions. The latter has enormous implications for bed use and service planning and perhaps even greater implications for community care.

The future is daunting; I left this report feeling there should be more of us, and that for there to be a decent future for psychiatry, the training and support of trainees is of paramount importance – for those of us lucky enough to have trainees.

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Psychosocial Interventions in Primary Health Care Settings in Europe Copenhagen: WHO. 1991 Pp. 22.

This is a report on a WHO European consultation about psychosocial interventions to promote health, prevent disease and care for people suffering from disease and disability. It is largely a description of 11 experimental initiatives which have succeeded or promise to succeed.

Members of the consultation, who came together from nine countries to a meeting in Bulgaria in 1989, aimed to identify common features of successful programmes, to suggest ways of strengthening the development of further programmes and to list conditions and principles which need to be observed when planning interventions.

Psychosocial interventions were defined as "a pattern of comunication and/or a contextual modification, providing positive changes in the current emotional and social factors related to the individual's health and illness". ("Contextual" should be understood to refer to organisational structures, normative base, and professional ideology; these determine the responses to any innovation.)

Here is one example – a behavioural intervention for children with school maladaptation, in Bulgaria, based on US and UK models: a psychologist trained in behavioural modification trained a group of four educational psychologists, each of whom then worked with a group of three primary teachers in their own school. These in turn successfully learnt the principles involved and developed a specific behavioural programme for one or two children in their classes. All the programmes were successful in achieving change.

Problems of discipline were easier to manage, but positive effects were also shown on scholastic activities. The experience also affected the communication styles of the teachers.

A particularly interesting detail in this experiment, with implications for adult education in any field and under any political system, was that the meetings between teachers and psychologists were more successful when they were able to see each other as equal colleagues in discussion. Being taught by a person seeing himself or being seen as of higher professional status, posing as instructor, aroused resistance.

Did the consultation achieve its aims? Yes, as one of a sequence of meetings. Conditions for success are proposed in the conclusion. Examples are: "Psychosocial interventions require a multi-disciplinary, multi-level and multi-focal approach ..." "Intervention techniques should be tailored to the client's specific problems and needs ...". "At the level of primary care, training of the family doctor, primary health care team and public health doctors is of key importance. Training must be focused on how to carry out interventions and not simply be a statement of tasks".

Among 11 recommendations, here is one example: "Follow-up from this meeting should include further meetings on stress management techniques, psychosocial interventions suitable for the school system and for fostering the psychological competence and coping skills of adolescents and a meeting that would bring together mental health professionals with family doctors, representatives of informal groups and other interested parties."

A report with substance, most of it worth the effort to read.

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Out of Harm's Way By Philip Bean, William Bingley, Ian Bynoe, Alison Faulkner, Elaine Rassaby and Anne Rogers. London: MIND Publications. 1991. Pp. 199. £13.50.

In 1987 Anne Rogers and Alison Faulkner published the results of a study looking at the assessment and outcome of people referred by the police under section 136 of the Mental Health Act 1983 (England and Wales) to three different places of safety. The work was published by MIND in *A Place of Safety* and it clearly showed that outcome was largely determined by where and by whom the patient was assessed.

Out of Harm's Way forms the second and third stages of a three stage investigation by MIND into the use of section 136. Working within a defined area of London the researchers followed through the whole section 136 procedure from the time the police entered the encounter with the person, through the processing of the encounter at the police station, to the referral to a psychiatric hospital.

Information was collected from police records, interviews with the arresting officers and the interviewing psychiatrists, and from a variety of questionnaires. A huge amount of information