> "Bill Harvey was driven into retirement by alcoholism. Angleton too was drinking far more than was good for him and had begun to look not merely pallid but genuinely ravaged. His mood changed too. He became increasingly introspective and the dry humour became less and less visible. He seemed pent up and aggressive, trusting fewer and fewer people who were turning more and more against him. Drinking, smoking and fishing were Angleton's main releases. Barry Russell-Jones told me in amazement of accompanying him on a fishing trip to a stretch of river he owned in Idaho and finding that Angleton had buried bottles of Jack Daniels under the water at 100 yard intervals so that he could never be caught short".

The French Intelligence Service appears to have had similar habits but claret replaced Jack Daniels.

> "Marcel Chalet was the Deputy Head of the French D.S.T. The night before I left Paris he took me out to dinner. The restaurant was discreet but the food was excellent. Marcel was an attentive host, providing bottles of the best claret, and regaling me with a string of waspish anecdotes about the perils of Gallic intelligence work. 'And you my dear Peter, have you had any luck with radiation?' I choked momentarily on my claret. 'Not much', I replied. Marcel filled my glass patently disbelieving my every word. Like true professionals we turned to other things and never discussed the matter again".

Less is known about the drinking habits of those in the Russian Secret Service, but in view of the known heavy consumption of alcohol in Russia it would be no surprise to discover that they too had a problem. Wright obviously is not in a position to give much information about this but there are a couple of tantalising glimpses. Frantisek Tisler was a double agent who was being run by the FBI and they had handed on to MI5 items of his intelligence which related to British security.

> "Tisler claimed he had gone back to Czechoslovakia in the Summer of 1957 and met by chance an old friend, Colonel Pribyl, who at the time was also on leave from his posting to London as a military attache. They had got drunk and Pribyl told Tisler that he was running an important spy in Britain, who was designing simulators for use in a guided missile project".

The only other Russian information was about another defector, Oleg Lyalin.

> "Lyalin soon began to exhibit the strain of leading a double life . . . Lyalin began to drink too heavily, and when he was posted back to Moscow we decided to bring his ordeal to an end . . . Almost immediately our plans fell apart . . . 'Lyalin's blown. He was arrested for drunken driving a few hours ago and is in the clink at Marlborough Street'. The Legal Department had to apply for formal immunity from his drunkeness charge because of the risk of an assassination if he were brought before an open court.

At the end of the book Wright's criticism of one of his colleagues comes as no surprise.

> "Traditionally K. Branch was MI5's prestige department and F. Branch its poor relation, shunned by the brightest officers and run shambolically by an amiable tippler".

Alcohol consumption subtly pervades this book. It may partly account for Wright's almost paranoid obsession that there was a further mole within the Security Services, although he can provide little support for this belief. His judgement must be questioned; the case for a mole being generally based on uncorroborated evidence of defectors from Russia or Eastern European intelligence, one of whom was considered insane by the CIA. His belief remains unshaken because of the peculiar difficulties of refuting causal hypotheses in intelligence work. The area of uncertainty which still has not yet been resolved is whether there may have been a plot by elements of MI5 to destabilise the Wilson government of 1974. This raises a question of major public interest which will not go away and will doubtless lead to further litigation in Strasbourg in a couple of years time.

This book can be recommended to anyone interested in studying the consumption of alcohol in obscure places. If positive vetting had prevented the recruitment of excessive drinkers to the security forces there would not have been the betrayals. As David Lloyd George said in 1915, ". . . if we are to settle with German militarism we must first of all settle with the drink. We are fighting Germany, Austria and the drink, and as far as I can see the greatest of these deadly foes is drink".

There is a ray of hope however. Vodka must be doing even greater damage to the Russian Secret Services.

THOMAS BEWLEY

*Senior Lecturer,*
*Department of Addictive Behaviour,*
*St George's Hospital Medical School,*
*London SW17*

This review is reprinted with kind permission of the Editor, *Irish Medical Times.*

**Treated Well? A Code of Practice for Psychiatric Hospitals.**
By Good Practices in Mental Health and Camden Consortium. 1988. Pp 23.

Anxiety and concern about the care and treatment of psychiatric patients has been with us for a long time. Anti-psychiatry has also been with us for a long time. Campaigns against — and attacks upon — psychiatry often use the ammunition provided by those who are concerned about quality of care in the psychiatric establishments. This is a great pity.

There is no doubt that many psychiatric hospitals in the past were dreadful places. There is equally no doubt that at the present time many psychiatric

patients are treated less well than they should be. This did not, and does not mean that all psychiatry is bad and all psychiatrists should be stood against the wall. It does mean that institutions, be they large psychiatric establishments or small general hospital units, can easily develop bad practices which become enshrined as rituals. There is a constant need for institutions large and small to examine – and re-examine – their practices and change – and re-change – them so that the care of the patient can remain the paramount objective of that institution and its staff.

When I started to read *Treated Well?* I felt rather sad that such a publication was considered necessary in 1988. A little thought quickly changed the sadness to an acceptance of reality. This booklet, which has been produced jointly by the Camden Consortium and Good Practices in Mental Health, is a Code of Practice for psychiatric establishments. In my professional lifetime there have been quite a number of codes of practice, all generated by scandal or serious concern about the treatment of the mentally ill. We still need to be reminded.

This Code of Practice, as distinct from many others, is based on what patients, and ex-patients, think of the care they received. The result is an excellent publication. To give an example, here are the recommendations at the end of the short section on Hospital Admission. The recommendation on Accident and Emergency Departments is included because a significant number of patients said they were admitted by way of the local A & E Department.

> Accident and Emergency staff should be trained to deal with people in acute mental distress and should have more knowledge of mental health.
>
> An understanding person should be available to talk to those in distress.
>
> Explanation should be given for any delays, with reasonable estimates of when a doctor will be available.
>
> The initial interviews should always be carried out in a private room.
>
> Administrative information requested should be kept to a minimum.
>
> Induction information should be provided on ward routine and facilities. This should also be provided in a written form.
>
> Patients should be made to feel welcome, introduced to nursing staff and asked whether they want to be introduced to the other patients.

I doubt if anyone could quarrel with these recommendations but how many hospitals observe them! How many A & E Departments train their staff to deal with people in acute mental distress?

I could find nothing to disagree with, except that I felt it a pity that the term 'voluntary' patient was still being used in 1988. I also wondered how you could explain to anyone the real difference between a consultant and senior registrar without lapsing into Monty Python humour. I imagine some will be a little more critical, particularly in relationship to the right of patients to see their Notes.

However good we think our service is, it would not be amiss to read *Treated Well?* The checklist at the end is excellent and I was rather disappointed with my service when I used it. I will certainly try better next time.

TONY WHITEHEAD

*Consultant Psychiatrist*
*Bevendean Hospital, Brighton*

**The Society of Clinical Psychiatrists. Recruitment into Psychiatry. (SCP Report No. 14)**

This Report has had a long incubation period and may now be out of date as there is anecdotal evidence from around the country that the recruitment problem is lessening gradually. In 1977 the Society of Clinical Psychiatrists set up a study group to examine recruitment, an open meeting was held in 1980 and a preliminary Report was published in order to have the views of the Society published before the proceedings of the Cambridge Conference held in 1982. Their concern about recruitment results from the fact that the proportion of graduates at British Medical Schools expressing a preference for psychiatry has remained constant between 1974 and 1983.

The Report consists of a thorough review of the published literature concerning recruitment, together with the views of certain selected eminent people. The review integrates data from the UK and USA in the usual framework of: the entrants to medical school, the effects of the psychiatry clerkship on recruitment, the medical schools that produce many psychiatrists and the relationship between psychiatry and general medicine.

In short, there is no evidence that can answer the question, "Why has recruitment into psychiatry been poor?" It is the lack of a clear answer to this question which allows many views to be expressed. The study group has chosen views from within its own members and prominent figures at medical schools which are at the extremes of the recruitment figures. But the reliance on these stated views is the weakest aspect of the report.

Some will agree with the views of the psychiatrists, others, like myself, will disagree. The authors view the situation pessimistically. They feel that psychiatry can be made more attractive if it is made more like the rest of medicine but their own view is that it should be moving away from medicine, rejecting the medical model, and towards psychology. They do admit that medicine needs to be influenced by