Grendon Prison: Report of Advisory Committee

On 25 July 1985, Lord Glenarthur announced in the House of Lords that the first report of the Advisory Committee on Grendon Prison has been published that day. The Government accepted the broad thrust of its proposals, in particular the central recommendation that Grendon should continue to concentrate in the main on group therapy, with the therapeutic community constituting its predominant form of therapy. The Committee has also recommended that the arrangements for referral and induction of inmate patients should be improved; that the prison hospital should be reorganized and one floor converted to use as a small unit for the temporary care of inmates who suffer acute psychiatric breakdown elsewhere in the prison system; and that a research strategy and programme should be established with links with external academic departments.

Mental Health Act Commission

On 25 July 1985, the Minister of Health replied to a question by Mr Harvey Proctor and said that the estimated cost in 1985–86 of the Mental Health Commission is £1,022,000. Nineteen staff are employed at the three secretariat offices. Seventy-one per cent of the total cost is for the fees and expenses of Commissioners and Second Opinion work. The remainder is for staff salaries, accommodation and general expenses.

Care of mentally ill and mentally handicapped

On 11 July 1985, Mrs Renée Short, Chairman of the Social Services Committee, initiated a debate on the Committee's report on the care of the mentally ill and the mentally handicapped. This was a wide-ranging debate which gave an opportunity for contributions from many Members, and it is not possible to summarize the contents in the space available here. The debate is reported in *Hansard*, Issue no 1355.

The House of Commons adjourned for the Summer Recess on the 26 July 1985 to reassemble on 21 October 1985. The House of Lords adjourned for a similar period. During the Summer Recess, on 2 September, in a Government reshuffle, Mr Barney Hayhoe, MP, previously Minister of State at the Treasury, replaced Mr Kenneth Clarke, QC as Minister of Health. Mr Clarke was appointed Paymaster General.

ROBERT BLUGLASS

Correspondence

Career structure and recruitment in psychiatry

DEAR SIRS

The Collegiate Trainees' Committee (CTC) has considered the President's reply to the Committee's Open Letter (*Bulletin*, June 1985, **9**, 118), but fails to find it reassuring. The Committee senses a distinct lack of urgency in the College's view of the problems.

The recently published Fifth Report from the Social Services Committee recommends that the Government, through the NHS Management Board, issue clear guidance to regions on how they should fulfil the policy of expanding consultant numbers to correct the manpower imbalance. The new, effective and accountable management structure may well succeed where the old structure failed. As a result, the likelihood of the Short Report being implemented is not as 'remote' as the President suggests.

The CTC believes that the days of difficulties in recruiting suitable trainees to psychiatry are fast coming to an end; and indeed there is a bottleneck now at the transition from registrar to senior registrar. This could be turned to advantage if the College sought an urgent increase in consultant and senior registrar numbers. Thirty years is too long to wait for a realistic career structure and a better quality of service. The CTC wishes the College to back its policies with actions rather than words.

Expansion of senior grades would enable the College to use the approval exercise to trim the registrar grade, leaving a balanced number of posts of good training quality.

As for the consultant based service—the CTC agrees with the President that there are attractions as well as problems in this form of working. However, the CTC believes that the College does not have time to monitor experiments one by one. If the College does not have proposals for running a consultant based service prepared, the NHS Management Board may well impose a medical staffing structure to run such a service. An imposed staffing structure may be to nobody's liking! Of course the College should monitor the developments in Hartlepool, but it should also be actively involved in promoting discussion, experiment, and evaluation in many areas.

JULIE A. HOLLYMAN
On behalf of the CTC

Collegiate Trainees' Committee
Royal College of Psychiatrists

Medical experience for the psychiatrist

DEAR SIRS

In replying to C. J. Thomas's article, 'Does Medicine Need Liaison Psychiatry?' (*Bulletin*, August 1985, **9**, 157–158), I must take issue with Dr Thomas's imagined difficulties for the prospective psychiatrist to gain medical experience. These are of course present, but not insurmountable.

Having fully declared my interest in a career in psychiatry, I applied for and was appointed SHO in geriatrics at the hospital in which I had completed my medical house jobs, and at the end of that six months' appointment, I gained a place on their two-year general medical rotation specifically designed for training doctors to take the MRCP. I am very grateful to that hospital (East Birmingham) for the training opportunity

which they gave me, but it seemed to me that the appointments committee who had to choose three candidates from 150 applicants were more interested in these following three attributes than in the intended future career of the applicant: (i) Will he do the job well?; (ii) Can I work with him?; (iii) Is he committed to taking the MRCP with a fair chance of passing it?

Of the three of us appointed that day, one is in general practice, one is a registrar in medicine and I am a registrar in psychiatry; we all have the MRCP.

In conclusion, I take serious issue with Dr Thomas's contention that, 'If physicians are serious in their request that psychiatrists should have further experience then perhaps the two respective Colleges need to consider jointly the best method for achieving this.' Rather, if a trainee is serious in his intention to become well trained, then he needs to consider seriously the best method for achieving this himself.

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Distinction awards in psychiatry

DEAR SIRS

I would like to follow on from Professor Rawnsley's note about distinction awards in psychiatry (*Bulletin*, September 1985, **9**, 187). Since I have been a member of the SE Thames Regional 'C' Awards Committee I have been disappointed at the number of psychiatrists put forward from the districts, and some years none have been proposed. It might be that few psychiatrists would be accepted even if names were forthcoming, but unless there are nominations I can do nothing to support deserving colleagues.

To my mind, an important reason for this state of affairs is the problem, unique to psychiatry, of the relationship of the large psychiatric hospitals to associated general hospitals. Many psychiatrists in the SE Thames Region still have the majority of their beds in a psychiatric hospital in one health district while their catchment area is likely to be in another. Thus, should they be proposed for an award by the district with the psychiatric hospital or the district containing the catchment area, where there are usually general hospital outpatient sessions? One can only suspect that, quite often, the consultant does not get proposed by either district. I believe this situation is overcome sometimes by a group of award holders at a particular psychiatric hospital taking the initiative and putting forward appropriate colleagues to one or other district awards subcommittee. Of course, if the psychiatric hospital has no award holders then this solution is not feasible.

These are difficulties that I perceive in relation to adult psychiatry. The problems seem worse for consultants in child psychiatry and, in my view, they are almost hopeless for consultants in mental handicap. But the reasons are similar. Mental handicap hospitals usually lack any relationship at all to general hospitals, and child psychiatrists tend to work in an individual way in the community, usually with some general hospital associations, but over a wide territory.

The regional awards committees also receive names from the regional officers and from the Royal Colleges, but these may not always have the same weight with the committee members as do the recommendations from their own body of working consultants.

I annually seek advice from the chairmen of the regional specialty subcommittees for child psychiatry and mental handicap, but even then these nominations have to be processed by relevant committees, and it is not always practicable to arrange this. I would be interested to know the views of awards committee colleagues in other regions. It may be that a national review of the situation is required.

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'Tactical Exercises without Troops'

DEAR SIRS

My reading about the delivery of health care in the psychiatric services has covered a period of some 25 years. It has included, in my early days, literature on the day hospital movement; has passed through the reading of plans for the development of services (characteristically indicated as being without new resources—by analogy with what I learnt in the Army was called 'TEWT', that is, 'Tactical Exercises without Troops'); and is brought up to the present day by: 'Understanding the Italian experience' by Kathleen Jones and Alison Poletti;[1] Rosalind Furlong's article in the *Bulletin*;[2] and David Parfitt's article in the *British Journal of Clinical and Social Psychiatry*.[3]

It was not reading alone that led me to two axioms in psychiatric care, but also a holiday visit over several days to the city of what an 18th or 19th century writer would have called 'W-', and its pedestrian precincts, where I observed a lot of behaviour that has almost disappeared from my own long-stay wards.

The axioms are: (1) If a new type of resource is developed and funded this has no effect on the care of those whose need is greatest, and is most specifically for psychiatric as opposed to generally pastoral care; (2) If a new facility is developed without new resources, it is to the maximum detriment of those in maximum need.

I fear in the next decade or so that the fundamental, indeed, axiomatic nature of my second notion will be more frequently demonstrated than the first, but I would welcome a response both from those who agree and those who disagree with me before we have the benefit of hindsight.

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[3] PARFITT, D. (1985) Asylum 1929. *British Journal of Clinical and Social Psychiatry*, **3**, 3–5.