survivors following a disaster reduces post-traumatic stress disorder (PTSD) or other psychological morbidity, estimated to be 20–50% at one year (Raphael, 1986a). This is perhaps because follow-up research has considerable practical and ethical difficulties. However, Raphael (1986b), in her book on disaster management, strongly advocates counselling, and points to analogies with the phases of bereavement, and her own work suggesting that bereavement counselling reduces subsequent abnormal grief and psychiatric morbidity (Singh & Raphael, 1981).

There has been a succession of 'man-made' disasters in Britain in recent years – Bradford, Clapham, Hungerford, Kegworth, Kings Cross, Lockerbie, Manchester Airport, Piper Alpha, Zeebrugge – brought sharply into focus by media attention. The unique nature of each event makes planning for counselling in Major Accident Schemes an impossibility. However, all doctors and health professionals should be aware of the psychological impact and possible psychiatric sequelae of such traumatic events. From the Sheffield experience, and a review of the literature, I will draw the following conclusions:

(a) Early counselling for survivors is probably useful for some individuals.
(b) It is impossible to predict which survivors are going to be most deeply affected by their experience. In the extensive American literature on PTSD, it remains controversial whether the intensity of the experience or premorbid adjustments is more important in the subsequent development of PTSD (Breslau & Davis, 1987). Counselling should therefore be offered to all.
(c) In the chaos prevailing after a disaster, mental health professionals should target specific groups to be offered counselling. For hospital in-patients, counselling should be organised rapidly, as patients admitted for observation during triage are likely to be discharged early. The degree of physical injury does not correlate with the degree of psychological injury.
(d) Counselling is best carried out by social workers (though clergy may be more helpful for some individuals). Social workers have experience of crisis work and bereavement counselling, and in addition are best placed to offer practical help (e.g. in Sheffield, offers of accommodation for relatives or lifts back to Liverpool). The specific skills of psychiatrists and psychologists in assessing and treating mental illness (as opposed to mental distress) are not necessary in initial counselling, though may be relevant in consultation, staff support, or later psychiatric morbidity.

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Research attachments

DEAR SIRS

May I offer support for the benefits of a research option for trainee psychiatrists as concluded by Foerster & Meadows (*Psychiatric Bulletin*, June 1989, **13**, 301–302), and describe a possible alternative to a full time 'intercalated' post.

I was able to negotiate a three day per week research attachment for five months immediately after successful completion of the MRCPsych examination. The remaining two days per week were spent in continuing an existing general adult psychiatry out-patient clinic and developing a newly established community clinic, working from a general practice medical centre.

The research project was to expand and consolidate a long-standing interest in the emotional and cognitive consequences of excessive alcohol consumption (Hambidge & Johnstone, 1986; 1987). I found the opportunity to spend time critically examining the literature and experimenting with clinical research possibilities a welcome and very beneficial change from the intensive acquisition of knowledge required for the examination. The time was in no way a 'holiday' but gave a valued opportunity to study subjects that could not otherwise be effectively looked at with the daily demands of general professional training in psychiatry.

The manpower implications of this half time absence need to be considered. However, in my opinion, the benefits to the trainee of such an intensive period to consolidate an ongoing research

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interest far outweigh the negative aspects. Indeed, such an option may be the only practical way to provide meaningful research experience to trainee psychiatrists in peripheral units.

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Management training for Scottish senior registrars in psychiatry

DEAR SIRS

Consultant psychiatrists have long been involved in different aspects of management. With the advent of the Griffiths' Report (1984), it became necessary for clinicians to acquire new management skills. To address some of these issues the Scottish Division of the Royal College of Psychiatrists formed Management Group in 1986. Part of their remit was to incorporate management skills into general professional and higher professional training.

In 1989, this Group joined forces with the Management Development Group of the Scottish Health Service to establish two week-long residential courses for all Scottish senior registrars in psychiatry. We attended the first of these courses in March 1989 in Edinburgh. The course was based around two facilitators and was supplemented by a number of guest speakers. Management skills were acquired from a mixture of factual and experiential learning covering a number of topics — including communication, team work and leadership, conflict and negotiation, committee work and time management. At the end of the week a review session was held at which participants resolved to make use of newly acquired management skills.

It is clear that close co-operation and improved understanding between managers and clinicians is essential for the future provision of a good service to the patient. The course which we attended undoubtedly offered an insight into different aspects of management, and all Scottish senior registrars now have the opportunity for management training organised by the Management Group of the Scottish Division. We write to urge the College to create similar courses nationwide. It is also our belief that an effort should be made to educate non-medical managers about the needs of the clinician.

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Compulsory treatment of patients remanded by Courts

DEAR SIRS

In November 1988 we admitted under Section 25 of the Criminal Procedure (Scotland) Act 1975 a 35 year-old man who had been charged with attempted murder. At this stage in the legal process he had not pleaded to the charge and the Court had "continued the case for further examination" and under section 25 (1) of the above Act had "remanded or committed for trial a person charged with any offence who appears to the Court to be suffering from mental disorder".

By the end of November 1988 two separate consultant opinions had been given to the Court and both were of the opinion that the accused was insane in bar of trial and that disposal by means of Section 174 (1) and (3) of the Criminal Procedure (Scotland) Act 1975 was appropriate, i.e. a Hospital Order should be imposed. However, as is often the case in Scotland, the case has not yet gone back to Court for the Court's disposal. The 110 day rule applies to this case, i.e. if the accused is not brought to trial within 110 days of the first day of incarceration then he must be liberated on day 110.

The problem which then developed was that the patient, or is he a quasi-prisoner, showed a deterioration in his condition, rejected the offer of any drug treatment and began to cut back on his diet, believing his food to be poisoned. The diagnosis made was of paranoid psychosis.

Concerned about the possibility of a life-endangering situation developing, we contacted the Mental Welfare Commission for advice regarding compulsory treatment. It was our opinion that this man was a quasi-prisoner and, as in the case of prisoners, compulsory treatment could not be instituted. However, the Vice-Commissioner, who is a psychiatrist, took the view, speaking 'colleague to colleague', that after two doctors had registered their opinion that the man suffered from a psychiatric disorder and was insane in bar of trial they were implying that he required treatment and that compulsory treatment would be justifiable.

Taking the matter further with the Central Legal Office of the Scottish Home and Health Department, the opinion from there was: 'Having looked at the Acts, particularly Section 70 of the Mental Health (Scotland) Act 1984 we feel with removal to hospital