Reviews

Community Mental Health Centres/Teams Information Pack.
Edited by Rose Echlin. Good Practices in Mental Health/Interdisciplinary Association of Mental Health Workers. 1988. £4.95.

Good Practices in Mental Health and the Interdisciplinary Association of Mental Health Workers are two organisations concerned with disseminating information, stimulating development, and promoting interdisciplinary work in mental health. Following a Kings Fund conference they have brought together 13 papers in a loose-leaf folder which include the issues of planning and targeting, working with the community and with service users, organisation, management and public relations. This formidable brief, ranging from the complexities of community development work to the importance of having one's own headed notepaper, is executed though a format of concise theoretical papers presenting key points for consideration, followed by papers giving examples of practice.

Rose Echlin's introduction places the British Community Mental Health Centre/Team (CMHC/T) movement in perspective and draws comparison with the American and Italian experience. Different models of service delivery and their aims and limitations are explored, and a broad definition of a CMHC/T given as "a local accessible community mental health service". This is followed by what is perhaps the single most valuable paper to anyone involved in establishing or running a CMHC/T; the contribution from Davidson and Koch on Planning and Development. A point-by-point series of questions and imperatives cover the issues and potential pitfalls in planning, running and developing a new service. Some of these issues are further developed by Ovretveit *et al* with particular emphasis on the critical role of keyworkers and the team co-ordinator.

Problems of inter-disciplinary working are explored by Purser *et al* with a team exercise examining a "dirty dozen" commonly experienced problems of team functioning and a useful agenda of critical issues for discussion by the team. These include matters of operational policy such as rules governing power and leadership, shared responsibility for service development and evaluation, service priorities and ways in which consumers have access and feedback on the service. Staff process issues are also discussed, such as the extent to which models of mental health are agreed amongst team members, discriminating between interprofessional conflict and personality clashes, retaining professional identity and coming to terms with differing pay scales within the team. The authors suggest the above should be raised at the team's first meeting together, although experience would suggest that this amount of material would keep most workers in animated discussion for months. This perhaps underlines the need to begin working on these issues at the earliest possible opportunity.

In looking at relations external to the team, Grey *et al* offer some pointers towards solutions to some of the issues described above. Most of the material is covered in more detail elsewhere. However, the paper usefully draws attention to the danger of an "idealised perception" of the CMHC/T generating anger and hostility among other agencies. This important issue is further developed by Milroy and Peck in their excellent paper on working with the "community". The work of liaison with other groups is described as an on-going process rather than a one-shot intervention and teams are warned to expect cynicism from other agencies when they suddenly find statutory workers taking an interest in "community" issues.

Given the increased attention being given to consumer satisfaction (for example in the last Griffiths[1] report) a paper devoted to the involvement of service users in CMHC/Ts was very welcome. Bassett *et al* state the case for user involvement while realistically reviewing some of the barriers to this aim being realised such as threat to professionals, access to case-notes and issues of authority and accountability. The weakness of the paper lies in its relative neglect of issues concerning how to introduce user involvement and where responsibility for this lies. This could usefully form the basis of another pack.

A central concern of CMHC/Ts has been balancing the need to respond swiftly to crises against provision of services for people with long-term disabilities. A trend towards dealing with acute crises and the "worried well" has been noted. Newton, in describing the work of the Coventry Crisis Intervention Team, offers one model for crisis intervention casework linked with a "social committee" providing longer term provision for some ex-clients. However, this is one area in which the pack offers little guidance despite it being a central concern of the introduction.

Three other services are discussed and 14 briefly summarised. Although some of the points from the theoretical papers are exemplified and some further

good ideas offered, the detail is inadequate to allowing a full appreciation of the process and development of the teams.

Overall, the pack aims to cover an enormous range of topics and does so in a concise and readable fashion. Primarily, the pack seems to offer a checklist of critical issues with guidelines on practice and is clearly aimed at those already involved in, or setting up CMHC/Ts. The format means that there is some repetition and redundancy and complex issues are not explored in depth. However, the topics are well chosen, the issues therein highly pertinent and the few pointers on practice invaluable. The pack offers a very useful tool for orientating anyone involved with planning, developing or working within CMHC/Ts towards the central issues and further readings are usually included.

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Reference

[1]GRIFFITHS, R. (1988) *Community Care: Agenda for action. A report to the Secretary of State for Social Services.* London: HMSO.

Distinction and Meritorious Service Awards for Hospital Doctors and Dentists in the NHS. By B. Edwards and G. W. Pennington. Health Services Manpower Review, University of Keele. 1987. Pp. 40.

As the question of Consultant Merit Awards appears on the political agenda yet again the publication of this pamphlet is timely. Written jointly by an eminent and experienced NHS administrator and a consultant chemical pathologist, it provides an unvarnished factual account of the history, development and present functioning of the system of Distinction and Meritorious Service Awards, to give them their full title.

The Spens Committee proposed the system in 1946 and, perhaps surprisingly, Aneurin Bevan accepted it at the inception of the NHS in 1948. Spens decided that, if the recruitment to, and status of, specialist practice was to be maintained specialists must be able to feel that more than ordinary ability and effort received an adequate reward and that a 'significant minority' of specialists should have the opportunity of earning a salary comparable with the highest which can be earned in other professions.

The criteria for receiving an award are set out in the phraseology of Sir Stanley Clayton, a former Chairman of the Central Advisory Committee, who published them in 1979 and 1981. They are still broadly followed and are subsumed under the headings of 'Meritorious Service' and 'Distinction'. Meritorious Service includes direct service to patients or their GPs, improvement of the service, training and teaching, research and medical administration. Distinction is less easily defined but examples quoted include leadership in a clinical or scientific field, contribution of new ideas of proven worth and acknowledged leadership of a Specialty in a Region or the country. Sir Stanley employs some sharp turns of phrase, e.g. "An international reputation deserves respect, but is not established by a mere list of attendances at foreign meetings."

The machinery through which these criteria are applied is explained in some detail, including the composition and rôle of the various Regional and National Committees and the input of the Royal Colleges. The diagram setting out the interrelationship of these sources of advice is inaccurate with regard to psychiatry, as the College has the special privilege of making representations directly and via its Regional Award Advisers to the Central Committee without being filtered through the multi-specialty Regional Committees, although psychiatry is represented on these also. In the last resort a consultant can put forward his own case for consideration.

How does psychiatry fare at the end of the day? The pamphlet publishes the statistics according to specialty at 31 December 1986. The proportion of award holders in all specialties was 35.6% for 'mental illness' the figure was 33.6%, for child and adolescent psychiatry 20.8%, forensic psychiatry 22.8%, mental handicap 21.8% and psychotherapy 30.1%. The (1984) figures for Scotland show 28% for psychiatry (all specialties) compared with 35.7% overall. The distribution between different grades of award was proportionate to the overall figures. Some specialties seem to be especially distinguished, e.g. nuclear medicine 62.1%, neurosurgery 59.1%, neurology 56.1%, general surgery 49.5% and general medicine 46.4%, although age-structure has to be taken into account.

Is the system fair? Although judgements are made by our peers and advice is sought from many sources, because of the limited number of awards available each year, the system is, in the final analysis, a competitive one. Certainly at the 'C' level the margin between the award-holder and the non-award holder can be narrow. Also, despite psychiatry's privileged access, the Regional Committees wield the greater influence. This emphasises the importance of co-ordination and synchronisation of candidacy lists but differences of opinion do sometimes arise. The recent practice of selecting candidates at award-holders' meetings has opened up the system but