case conferences, especially those attended by professional workers in the community, such as general practitioners, social workers and community psychiatric nurses.

7. *Chronically Disabled Psychiatric Patients*

In view of the increasing number of chronically disabled patients now being cared for in the community by general practitioners with or without community psychiatric services, the trainee general practitioner must be able to recognize the needs of such cases in order to arrange appropriate care, treatment and rehabilitation (for instance by attendance at a day centre), or to arrange specialist advice and help. The trainee should have experience of patients receiving lithium therapy or depot injections of psychotropic drugs, and of methods of behaviour therapy for phobic conditions, alcohol dependence, etc.

8. *Psychiatric Aspects of Old Age*

Because of the widespread problems involved in the care and management and treatment of aged mentally disabled people in the community and in hospital, it is important that this area of experience should be included among the duties of the trainee, especially the recognition of depression, senile dementia and the physical and remediable causes of confusion. Experience should include a community setting and contact with appropriate community social agencies.

9. *Psychosexual Conditions*

There are relatively few centres where specialist experience in the diagnosis and treatment of psychosexual conditions can be obtained, but in view of the frequency of such problems in general practice the trainee might obtain insight from the hospital or unit if suitable experience is available. It is also necessary for the trainee to be aware of the effects which psychotropic medicines may have on sexual function.

10. *Family Crises, Marital Problems, and Counselling*

The general practitioner can be confronted with emotional problems associated with serious physical or mental disablement, the effect of acutely distressing medical information, of bereavement, marital conflict and many other situations in which a counselling approach is appropriate. The trainee cannot, however, hope to obtain sufficient counselling expertise within a single psychiatric SHO appointment of only six months.

11. *Special Areas of Experience*

In his relatively short tenure the trainee general practitioner would not normally participate in the specialty secondment or rotations necessary for the trainee psychiatrist, but any experience of child and family psychiatry, adolescent psychiatry, mental handicap, forensic psychiatry, and the treatment of dependence, though hardly representing more than an exposure, would nevertheless be helpful.

Postgraduate Educational Activities

The holder of an SHO post, whatever the specialty, is in training and must expect to supplement his in-post experience by a variety of learning activities, whether planned beforehand or *ad hoc*, both within the hospital where he works and outside. The postgraduate psychiatric tutor or the GP course organizer can advise on the availability of such activities and may be in a position to organize an individual programme, including special attachments.

Full use should be made of libraries, both in the department and in the postgraduate centre; and every effort should be made to attend audit and patient management reviews in the department, interdisciplinary meetings, and clinicopathological conferences of wider interest.

The concept of general professional training implies that in-post teaching should primarily be about the specialty itself, whatever the incumbent's eventual career destination. However, those trainees in hospital who are preparing themselves for general practice possess in the local day or half-day release course an opportunity to maintain contact with their peers and to take part in a programme of group work during which their specialty teaching can be related to the wider perspectives of general practice.

Report on Non-Consultant Medical Staffing Needs: Adult Mental Illness

This Report has been drafted by a Working Party of the College's Manpower Committee, which was set up to consider the medical staffing structure other than consultant, and also the contribution of the allied professions. The Working Party's recommendations on the first part of its remit are being circulated for discussion.*

*Members of the Working Party were Professor Steven Hirsch, Drs Fiona Caldicott, John Cobb, Francis Creed and Ashley Robin.

Background

The Manpower Committee has so far confined its discussion to establishing levels for consultant staff in all psychiatric specialties and special interests. These have been related to the population served and the recommendations have been passed to the Central Manpower Committee and to the Department of Health and Social Security.

Senior registrar and registrar posts are controlled centrally by the Central Manpower Committee (CMC) and dis-

cussions have taken place regarding the control of the senior house officer (SHO) grade, which it is proposed to monitor more closely in the immediate future. The effects of manpower control of training posts had already been felt, especially in the approval of staff for new units in Regions which have reached or are above the average national staffing levels. Intra-Regional distribution is in practice extremely difficult to implement, especially in psychiatry where the national average staffing level is generally considered to provide an inadequate service. It is clear that if a policy is accepted for relating the number of training posts to prospective career outlets in the consultant grade, even allowing for the expansion of the latter, there will be insufficient medically qualified staff to meet service needs unless a non-consultant grade is added.

Basic Assumptions

Two assumptions have been made which underlie the calculations and recommendations of this document. Firstly, senior registrars have not been included in the calculations because they do not provide routine care of patients in the same way as registrars and senior house officers. Secondly, a whole-time trainee (SHO/registrar) is considered to contribute 4/5th of the service of a whole-time non-trainee (e.g. Hospital Practitioner), since trainees should have two sessions per week for study or research.

Method

In order to provide an estimate of the staff required to give adequate services a selection of units were studied which both the doctors working in them and the College Approval Teams considered to be adequately staffed. It was decided to examine Teaching Hospitals providing either a full or a partial district service, DGH units and Psychiatric Hospitals separately. Some information was available from the survey of Teaching Hospitals prepared for the Joint AUTP/College Working Party by Professor Gerald Russell, Dr. K. Granville-Grossman and Professor Sydney Brandon. Comparable information was available from the College's Approval Exercise for Psychiatric Hospitals and DGH Units.

The time spent in training and the involvement of staff in training programmes has to be taken into account as well as the provision of services. The variation in work patterns, distribution of different grades and the composition of the team, make comparisons extremely difficult, and a pilot survey was therefore undertaken to assess the contribution of the medical staffing structure other than consultant.

A Six hospitals in each category (Teaching, DGH and Psychiatric Hospital) which had been given favourable reports by visiting College Approval Teams were chosen, and the non-consultant medical staff work load was examined in detail. The work load was examined under the following headings: in-patient commitment, out-patient department, day hospital, on-call frequency, over-dose policy, casualty duties, liaison psychiatry, teaching undergraduates, type of patient and local morbidity, geographical spread, amount of study and research, and number of non-medical professional staff (with a description of their duties).

B Individual contact was made with medical staff at some of the hospitals, and in addition hospitals known to members of the Working Party and thought to be adequately staffed were also contacted.

Results

Patterns of work in well-staffed hospitals are shown in Tables I and II. Included are examples of (a) Teaching Hospital with full District services; (b) Teaching Hospitals with partial District services; (c) District General Hospitals; and (d) Psychiatric Hospitals.

TABLE I

	Maximum Figures
1. *Teaching hospital with full District service* (including long-stay beds)	
Number of beds/trainee	15 (approx. 10 acute & 5 long-stay)
Number of day patients/trainee	5
Number of OP/liaison/emergency/teaching sessions/trainee	2-3
2. *Teaching hospital with partial District service* (no long-stay beds)	
Number of beds/trainee	10
Number of day patients/trainee	5
Number of OP/liaison/emergency/ teaching sessions/trainee	2-3
3. *District general hospital—psychiatric unit*	
Number of acute beds/trainee	13
Number of day patients/trainee	10
Number of OP/liaison/emergency/teaching sessions/trainee	2-3
4. *Psychiatric hospital*	
Number of acute beds/trainee	11
Number of chronic beds/trainee	45
Number of day patients/trainee	5
Number of OP/liaison/emergency/teaching sessions/trainee	2-3

Recommendations

In 1975 an 'average' consultant was responsible for 23 acute and 64 long-stay beds with about 23 day patients. An 'average' consultant also attended two out-patient clinics. It will be seen that at present broadly speaking an 'average' consultant would be supported by 2.5 trainees in the various aspects of the work described above. Should support in service areas be provided by non-trainees, the immediate figure for each consultant team would be 2.0 non-consultant

career grade doctors. Manpower planning demands that there should be a more rapid expansion in the number of consultants than in the number of trainees. Interim goals for the expansion of the consultant grade are outlined in the College's papers 'Providing a District Service for General Psychiatry, its Special Interests and Related Specialties: Medical Manpower Priorities' (*Bulletin*, December 1977, 5-7) and 'Medical Requirements of Teaching Hospitals (Adult Psychiatry): 1. The College Document; 2. Report to the Working Party' by Gerald Russell, Kenneth Granville-Grossman and Sydney Brandon (*Bulletin*, December 1978, 201-11) and recommend a 25 per cent increase in the number of consultants. If this figure is realized and therefore an increasing proportion of the service needs are met by consultants, the necessary support in a consultant-led team will fall to two trainees or 1.6 non-consultant career grade medical staff or an appropriately balanced mixture of staff in these grades.

Discussion

Local service needs, together with varying patterns of care, will determine adaptations of our basic recommendations both within the medical team and in conjunction with the allied professions. The recommendations we have produced are based on staffing levels in units which are considered to be reasonably well staffed, but even these barely allow the trainee sufficient time for study and should be considered as minimum levels rather than ideal ones. The Working Party was concerned with adult psychiatry and did not consider whole-time training in specialized areas such as, for example, psychotherapy, child psychiatry or neurology. The recommendations should be considered together with those made by the College for consultants as a working estimate of the medical staffing required to provide an adequate, comprehensive service for the mentally ill in England and Wales.

TABLE II

PRESENT SITUATION IN ADEQUATELY STAFFED UNITS

	Teaching Hospitals				District General Hospitals			Psychiatric Hospitals		
	Full District		Partial District							Profile of six hospitals combined
	A	B	A	B	A**	B	C	A	B	
Population served × 10^3	220	150	112	150	170	120	70	450	270	2153
Number of beds	160	150	62	40	94	125*	40	380 Chr 120 Acute	774 Chr 126 Acute	4368
Day places	58	60	50	20	100	36	30	90	44	361
Consultants (WTE)	6.5	3.5	4.1	3.5	4	3	3.3	7	5.5	41
Sen. Registrars (WTE)	6	4	3.5	1	1	—	1	—	1.7	9
Trainees	11	9	9	4.3	7	8	3	15	12	103
Undergraduates	200	120	90	120	—	—	—	—	—	
Liaison/Overdose/ Casualty sessions	1	2	1	2	2	2	?	1	2	
OP sessions	2	1	1	1	1	1.5	?	1	1	
Beds/Trainee	15†	16†	7	9	13	15 (12 Acute & 3 long-stay)	13	25 Chr 8 Acute	65 Chr 11 Acute	42.4
Day places/Trainee	5	6.5	5	5	14	4	10	6	4	3.5

*100 Acute & 25 long-stay

†both include "few" long-stay

**Juniors have less than one session/week for study/research

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