Correspondence

Seclusion of patients

DEAR SIRS

Many congratulations on publishing the procedures for the seclusion of patients in the Bethlem Royal and Maudsley Hospitals (*Bulletin*, November 1982, **6**, 199–200).

While the use of seclusion in a hospital setting may have been acceptable twenty years ago, I would suggest that the implementation of modern ideas about the care and management of psychiatric patients leaves no room for the concept of 'solitary confinement' as a way of dealing with disturbed people, either in an emergency or as part of a planned programme of treatment prescribed by a clinical team.

J. A. WILLIAMS

Bryn-y-Neuadd Hospital
Llanfairfechan
Gwynedd

Care in the community

DEAR SIRS

The Government's proposals call for hostels for long-stay patients run by Social Services Departments. For the care of such patients Social Work Departments would have to recruit Mental Nurses. In the Health Service good nurses can achieve status and seniority through the excellence of their clinical work. The nursing profession is beginning to learn that the good clinical nurse requires recognition. They are beginning to attach less importance to long administrative hierarchies. We have just opened this hospital's first hostel for long-stay patients. Nursing morale is superb. It is clear that good work at the hostel will be recognized within the service.

In 1971/4 I had the unusual experience of secondment to a Social Services Department to establish within it a therapeutic community for drug abusers, Alpha House. This was a good three years and I acquired a lasting affection for social work. However, I learned that social work is hierarchical to a degree that doctors can hardly comprehend. Virtually all administrators are former social workers. The almost automatic response to any problem is the appointment of an additional adviser or planner: rarely is there an attempt to improve the quality of actual social work. Promotion to senior post and consequent status is confined to qualified social workers, but subject to this, youth and brief experience of actual social work is no bar. What is more, within social work the residential worker has inferior status. With rare exceptions, such as the Principals of Assessment Centres, the work of the residential social worker is circumscribed and supervised by advisers and seniors qualified in field work.

With their present management practice and duties Social Work Departments may not run long-stay hostels particularly well. The nurses they will have to employ risk becoming second class citizens without real status. Only by retraining as social workers can they hope for improved status or seniority. If Social Work Departments are going to take over our patients, we shall have to try and help them in a way that will require a great deal of tact on our part. For myself I find it a daunting prospect.

IAN G. CHRISTIE

Knowle Hospital
Fareham, Hants

The Approval Exercise

DEAR SIRS

Dr Edwards makes some important points (*Bulletin*, November 1982, **6**, 201–2) concerning my article 'The trials of a Convener of an Approval Team' (*Bulletin*, August 1982, **6**, 132–4). Like him, I emphasized that it was becoming increasingly difficult to obtain improved facilities by means of proposing the Unapproved category, because of severely limited finances. But we should remember that the DHSS has made it clear that psychiatry in general should be spared cuts, having been deprived of resources for so long in relation to the more glamorous acute specialties. Should we bow to the inevitability of the economic situation and accept progressively declining clinical standards, or should the College maintain pressure to keep up adequate training with which will be associated adequate clinical care?

However, it seems to me that in the future practicality will dictate that fewer psychiatric units and hospitals will have the resources to train junior psychiatrists and this will involve restructuring of the medical staffing of a hospital. There will need to be more consultants, who might be helped by those in non-training grades such as clinical assistants and hospital practitioners. This might have to happen if a hospital is made Unapproved, although in these circumstances the status of the trainees in post is protected up to the end of their contracts. Some might argue that with more consultants for a hospital patient care would be improved because patients would be more often seen by experienced doctors. I should point out that it is definitely possible, although not easy, for a hospital to be regraded from Unapproved to Provisionally Approved, and then to Approved. I myself know one that has managed this.

In the same issue of the *Bulletin*, Dr Frost suggested that every Approval Visit should involve a senior registrar. I would agree with this completely and I am aware of the College encouraging Conveners to take a senior registrar along, and the value of that member of the team has been clearly shown in Dr Frost's letter. However, I report two

criticisms that I have heard. The first, inevitably, is financial. I have heard our College criticized because of the frequency of our Approval Visits relative to the other colleges, which have been approving their training schemes over a very much longer period. So there is pressure on Conveners to manage with one consultant colleague. Adding a senior registrar, however desirable that is, increases the expense significantly, but I agree that they are likely to make the Approval Visit more effective. The other criticism I have heard, Dr Frost mentions himself. In my article I pointed out that feelings can run high during Approval Visits and there may be much frank and even aggressive discussion. Consultants have said to me that they would rather that senior registrars were not present on these occasions. I do not comment on this, which Dr Frost very reasonably describes as 'not in front of the juniors'.

P. K. BRIDGES

Guy's Hospital Medical School
London

Damage to medical training through rapid change in health services

DEAR SIRS

Medical training entails learning about illness and treatment in the context of a society and health service. Rapid changes in the health service are making present training irrelevant. Resources that are essential components of therapy are being attacked by rigid financial policies. For example, many hospital Social Work departments have been unable to replace staff when funds are frozen. At least one nurse training school cancelled a term's intake of pupils without regard to the service implications for the future. According to Professor John Wing, Director of the Medical Research Council Social Psychiatry Unit: 'In a period of recession, it is well known that services develop unequally and there may be serious gaps in provision which particularly affect people with long-term disability.'

Although the Government has encouraged Regional Health Authorities to give priority to services for patients who are elderly, mentally handicapped, or mentally ill, these specialties are labour-intensive and costs continue to outstrip funding. Consequently, staff levels have fallen, dangerously in some districts, particularly in night nursing.

At the same time, changes in society, such as mass unemployment, involve an increased risk of illness, both physical and mental. This is producing a rising demand on medical and social services. Inevitably the less articulate chronically handicapped are put at a further disadvantage in the competition for dwindling services. Resettlement becomes impossible.

As psychiatrists in training from all parts of the British Isles we are opposed to public policies which lead to ill-health and impoverish services. We wish to draw attention to the consequences of such policies for our training. Unless the changes in progress are halted, little will remain but an emergency service, lean and competitive, but one for which our present training is inappropriate.

CHRIS THOMPSON

Maudsley Hospital
London SE5

Also signed by: K. O'DONOGHUE, J. GILBERT, F. MCMANUS, N. SIMPSON, G. CARTER, K. ROBERTS, M. BLUETT, F. MARGISON, S. BAILEY, A. LE COUTEUR, D. BRODIE, P. THOMAS, J. HOLLYMAN, S. PHILIPS, M. KACZMARCZUK.

Planning in child and family psychiatry

DEAR SIRS

The good physician makes sure that his treatment does not make the patient worse; we wonder if this is true of administrators.

During the further reorganization of the NHS, child and adolescent psychiatrists have had to take difficult planning decisions at short notice and without opportunity for consultation.

The Child and Family Psychiatric Service (CFPS) in Bedfordshire consists of three small clinics, and by the end of 1981 we were represented on both area and district planning teams. A CFPS area planning group consisting of practitioners, Community Physicians and Social Services adminstrators met regularly and had access to the Joint Consultative Committee (JCC) via the Joint Care Planning Team (JCPT). The consultant psychiatrists were also represented on district planning teams both for children's services and the mentally ill.

Because the area level of organization was to be abolished in the forthcoming NHS reorganization, administrators wished to disband the CFPS group. In future there would be two district health authorities within Bedfordshire, cutting off administratively one clinic in the north from two in the south. The practitioners in the CFPS group realized its importance as a base for overall planning of the service and decided to keep it in being even if its former link with the JCPT did not exist during reorganization.

The consultative documents issued by the new district health authorities did not mention CFPS Services, so all three clinics wrote pointing out that we were a *psychiatric* service and should be planned as such. This was accepted in the southern district, but was ignored by the northern district management team, which, without consultation, placed the CFPS in the Community Services unit. If these arrangements are confirmed, our service, split between two different planning units, may be worse off than before. We have, for instance, to plan jointly the training of junior psychiatrists studying for the Membership Examination, and this may be hindered by administrative separation.

At the moment our only united base is the CFPS group

criticisms that I have heard. The first, inevitably, is financial. I have heard our College criticized because of the frequency of our Approval Visits relative to the other colleges, which have been approving their training schemes over a very much longer period. So there is pressure on Conveners to manage with one consultant colleague. Adding a senior registrar, however desirable that is, increases the expense significantly, but I agree that they are likely to make the Approval Visit more effective. The other criticism I have heard, Dr Frost mentions himself. In my article I pointed out that feelings can run high during Approval Visits and there may be much frank and even aggressive discussion. Consultants have said to me that they would rather that senior registrars were not present on these occasions. I do not comment on this, which Dr Frost very reasonably describes as 'not in front of the juniors'.

P. K. BRIDGES

Guy's Hospital Medical School
London

Damage to medical training through rapid change in health services

DEAR SIRS

Medical training entails learning about illness and treatment in the context of a society and health service. Rapid changes in the health service are making present training irrelevant. Resources that are essential components of therapy are being attacked by rigid financial policies. For example, many hospital Social Work departments have been unable to replace staff when funds are frozen. At least one nurse training school cancelled a term's intake of pupils without regard to the service implications for the future. According to Professor John Wing, Director of the Medical Research Council Social Psychiatry Unit: 'In a period of recession, it is well known that services develop unequally and there may be serious gaps in provision which particularly affect people with long-term disability.'

Although the Government has encouraged Regional Health Authorities to give priority to services for patients who are elderly, mentally handicapped, or mentally ill, these specialties are labour-intensive and costs continue to outstrip funding. Consequently, staff levels have fallen, dangerously in some districts, particularly in night nursing.

At the same time, changes in society, such as mass unemployment, involve an increased risk of illness, both physical and mental. This is producing a rising demand on medical and social services. Inevitably the less articulate chronically handicapped are put at a further disadvantage in the competition for dwindling services. Resettlement becomes impossible.

As psychiatrists in training from all parts of the British Isles we are opposed to public policies which lead to ill-health and impoverish services. We wish to draw attention to the consequences of such policies for our training. Unless the changes in progress are halted, little will remain but an emergency service, lean and competitive, but one for which our present training is inappropriate.

CHRIS THOMPSON

Maudsley Hospital
London SE5

Also signed by: K. O'DONOGHUE, J. GILBERT, F. MCMANUS, N. SIMPSON, G. CARTER, K. ROBERTS, M. BLUETT, F. MARGISON, S. BAILEY, A. LE COUTEUR, D. BRODIE, P. THOMAS, J. HOLLYMAN, S. PHILIPS, M. KACZMARCZUK.

Planning in child and family psychiatry

DEAR SIRS

The good physician makes sure that his treatment does not make the patient worse; we wonder if this is true of administrators.

During the further reorganization of the NHS, child and adolescent psychiatrists have had to take difficult planning decisions at short notice and without opportunity for consultation.

The Child and Family Psychiatric Service (CFPS) in Bedfordshire consists of three small clinics, and by the end of 1981 we were represented on both area and district planning teams. A CFPS area planning group consisting of practitioners, Community Physicians and Social Services adminstrators met regularly and had access to the Joint Consultative Committee (JCC) via the Joint Care Planning Team (JCPT). The consultant psychiatrists were also represented on district planning teams both for children's services and the mentally ill.

Because the area level of organization was to be abolished in the forthcoming NHS reorganization, administrators wished to disband the CFPS group. In future there would be two district health authorities within Bedfordshire, cutting off administratively one clinic in the north from two in the south. The practitioners in the CFPS group realized its importance as a base for overall planning of the service and decided to keep it in being even if its former link with the JCPT did not exist during reorganization.

The consultative documents issued by the new district health authorities did not mention CFPS Services, so all three clinics wrote pointing out that we were a *psychiatric* service and should be planned as such. This was accepted in the southern district, but was ignored by the northern district management team, which, without consultation, placed the CFPS in the Community Services unit. If these arrangements are confirmed, our service, split between two different planning units, may be worse off than before. We have, for instance, to plan jointly the training of junior psychiatrists studying for the Membership Examination, and this may be hindered by administrative separation.

At the moment our only united base is the CFPS group