



columns

Russell Barton was a leading figure in the unlocking of wards in mental hospitals, in rehabilitation, and the move to community care in the middle of the last century.

As a medical student, Russell courageously worked in the recently liberated, infamous K.Z. Lager at Belsen. He qualified at Westminster Hospital in 1947. After National Service in the Royal Navy, he became a Registrar and Clinical Tutor (medical and psychiatric) at his old hospital. He then moved to the Maudsley Hospital under the formidable Sir Aubrey Lewis.

As a Senior Hospital Medical Officer at Shenley Hospital he led and inspired us to encourage patients with chronic schizophrenia to occupy themselves in small groups. He succeeded in unlocking wards, so transforming a situation in which half the 2000 in-patients in the hospital had been treated in three blocks of locked wards.

In 1960, he was appointed Physician Superintendent of Severalls Hospital, Colchester. He collaborated with Mapperley and Netherne Hospitals in a study, the results of which were published by Professors J. K. Wing and G. W. Brown in 1970. During the 8 years of the study, one-third of the long-term patients with schizophrenia improved clinically. The industrial work introduced at Severalls accounted for much of the clinical improvement there.

In 1971, he was offered financial incentives to relinquish his post and remain as one of the four consultants at the hospital: a firm believer in proper clinical leadership, he declined and moved to Rochester (NY) where he became Director of the State Hospital and Clinical Professor of Psychiatry at New York School of Psychiatry. He published *A Short Practice of Clinical Psychiatry* in 1975. In

due course, he retired from Rochester Psychiatric Center but continued to undertake medico-legal work. It is interesting to quote a press cutting in 1989 which recorded him as saying in Court, 'Translated literally, Mr Cleary, "distinguished colleague" means "bloody fool"'.

A certain extraverted flamboyance led some to underestimate him. Many of his aphorisms would put life into this account. On one occasion he said to me 'Not having been at the Maudsley, you will not have heard of Occam's razor'. I quoted the fourteenth-century original, at which his scorn deepened; 'At the Maudsley, it would have been regarded as a ridiculous affectation to quote it in Latin'.

Russell was a good friend and colleague and will be much missed.

Lindsay Hurst

reviews

Putting Assertive Outreach into Practice. A Development Tool for Team Leaders and Project Managers

By D Davidson and J Lowe
Brighton: Pavilion Publishing. 2001.
42 pp. ISBN: 1841960721

Leonard Stein, one of the original proponents of assertive outreach, was keen to reduce the 'pathological dependency' he felt was implicit in the individual keyworker model. Thus developed the 'whole team approach'; all the members of a team work with all the patients and share clinical responsibility. This aims to reduce both keyworker stress and the 'dependency' of the patients.

This pack, for developing assertive outreach teams, emphasises the importance of such an approach. However, many authorities in the area do not buy into this model. They argue that the road to independence is via a period of dependence and that forming individual relationships is important. On a practical level, trying to routinely rotate visits between all team members is inefficient and labour intensive. Engagement, so crucial to successful assertive outreach, can also become more difficult.

That there is any debate about this issue would be a surprise to those using this pack in isolation, as it sticks very much to the mantra that the whole team approach is the crux of successful assertive outreach. It is aimed at leaders of developing teams, and concentrates on

putting issues into practice. It consists of a training pack accompanied by a video. Also included are some clear, simple handouts covering the background and core components. The emphasis is on practical issues such as the daily hand-over, and training sessions are suggested.

The video presents footage of two teams, both in the voluntary sector, with no medical involvement. The 'whole team approach' is explained and the video demonstrates the degree of communication necessary to enforce this rigorously. Team members discuss the model from their perspective and you get a feel for their enthusiasm and dedication. However, the lack of medical input is reflected in the case histories; in one, a patient is left in his room not eating or drinking for 4 days and not having seen a doctor, while the team try to engage him and his family.

This pack may be of interest to developing assertive outreach teams, but will only be relevant to those who have already made an informed decision to adopt the whole team approach. The emphasis on teams in the voluntary sector does not reflect the self-contained teams with active medical membership suggested by the government's Policy Implementation Guidelines. Assertive outreach needs to be flexible, and many teams have found in practice that, rather than sticking rigidly to the ideology of the whole team approach, a mixture of both models has evolved.

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A Suitable Space. Improving counselling services for Asian people

By Gina Netto and others
Bristol: Policy Press/The Joseph Rowntree Foundation. 2001.
34 pp. £10.95 (pb).

This is a well-written account of a qualitative investigation into counselling services and their suitability for Asian people. Interviews were held with 38 Asian men and women to explore their perceptions and views about counselling, examine their experiences of accessing and using counselling services, explore their preferences for all types of service, and examine the cultural sensitivity of counselling provision.

Although respondents often put forward family and friends as confidants, it was clear that at times of distress they valued an independent source of support, and professional help, in particular. Understandably, those who had experienced counselling were greatly in favour of it and those with no such experience knew little of the services. Coping mechanisms included maintaining a semblance of normality and continuing as if nothing untoward had happened. This may explain non-presentation of distress to health and counselling services. Those with experiences of counselling had found it useful and were able to articulate the relief they experienced both metaphorically and in concrete terms, sometimes very shortly after beginning counselling. Interestingly, this relief was partially manifest as better sleep, less panic, less chest pain or fewer coughing fits. These