medical colleague any difficulties they experience in adapting to work within a multidisciplinary team.

Senior registrar training

Senior registrars bring their own skills to the team. This should be acknowledged, and they need to be allowed to pursue existing interests within the new setting. The skills they need to be given the opportunity to acquire are subtly different from those appropriate to the junior trainee: SRs should be given an active role in management. They also need to be allowed experience of independent functioning in community settings. This could include, for example, the experience of setting up and maintaining liaison meetings with local services such as the Social Work Department. The supervision they require often relates to the chance to review progress in acquiring these skills, and in discussing wider aspects of liaison and community work, rather than the more specific case-oriented supervision appropriate to the junior trainee. We suggest that experience in community psychiatry is appropriate at both stages in training.

The hallmark of community psychiatry is its liability to change. Practice is constantly reviewed, reconsidered and adapted. This plasticity of function is important, and the ability to adapt should be encouraged in trainees. Hence it is appropriate to help trainees acquire an understanding of principles and methods of working which can be altered to suit any setting in which they later find themselves.

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Community mental health teams

DEAR SIRS

It seems to be assumed that community mental health teams are "a good thing" and that we should all be working in them. However, I have yet to see clear aims and goals set out for community health teams or a reasonable, controlled trial to indicate whether such methods of working are achieving goals better than conventional methods.

The way the teams seem to be working is that a member of the team, of whatever discipline, is allocated to the GP practice and the received wisdom is that this is of benefit to that practice and is a better way of delivering psychiatric care to people suffering from a psychiatric illness than other methods.

As there seems to be considerable pressure, particularly in the health district I work in, for the community health team method of working to be applied throughout the District in the manner described above, I think some objective assessment of this manner of working needs to be done. I have yet to see such a study carried out.

Maybe the DHSS should address itself to this question of objective assessment of new patterns of working. The alternative way of providing help for people with psychiatric problems at primary care level is for the practice itself to employ a practice counsellor. Maybe this is just as effective a way of providing the appropriate care with psychiatric backup for more serious problems.

I would be interested to see some discussion on this. There seems to be a major difficulty about leadership, and roles and responsibilities of team members.

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Participating in primary care – a new model

DEAR SIRS

We enjoyed Mitchell's excellent paper on psychiatric liaison attachment schemes (*Psychiatric Bulletin*, March 1989, **13**, 135–137), but there are three points we should like to make. First, the percentage of consultant psychiatrists in Scotland who spend some time in primary care settings is even higher than he suggested – in fact 56% (Pullen & Yellowlees, 1988). Second, it should be pointed out that the models described are not mutually exclusive. The Scottish survey showed that most psychiatrists use a mixture of models and, once in the primary care setting, become involved in a variety of activities with other members of the primary care team.

Finally, there are two major problems associated with trying to provide a liaison service to *all* general practitioners in a sector or district catchment area. Most models of liaison can only be offered economically to larger group practices or health centres (excluding most smaller practices and single-handed GPs) and, once set up, there is an expectation that the service will continue even though, over time, the amount of face-to-face contact may have declined

and the practice reverted to a 'shifted out-patient model'.

At present we liaise regularly with seven practices in two health centres in south-west Edinburgh using a range of Mitchell's models. In order to allow us to offer a liaison service to *all* GPs in south-west Edinburgh, we have devised a new model – a negotiated, focused, time-limited model. Each practice in the sector, irrespective of size, is being offered in turn a six month service of one session per fortnight. The task is negotiated at the outset, the time commitment on both sides agreed and the duration of service spelled out. The task will probably vary from practice to practice but may well turn out to be one of those described by Mitchell. However we expect the new model also to throw up new tasks. The first new practice has asked us to review a cohort of 'regular surgery attenders' to screen them for treatable psychiatric pathology and help devise management plans. The second practice is discussing benzodiazepine prescription and withdrawal.

We hope that this new model will allow us to work more closely with smaller practices and single handed GPs in the sector. But a spin-off will be the stimulation resulting from our attempts to tackle the unusual variety of new tasks set for us.

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Patient administration systems

DEAR SIRS

I have recently become aware of a patient administration system which is widely used in general practice and distributed free of charge or against a small leasing fee by a company called 'Medital'. Apparently this system is due to be adopted generally by the NHS for all general practitioners.

Although this system seems to have some advantages, I was very concerned when I checked out items relating to psychotherapy where I found rather exotic forms of therapy represented on it, such as five different types of aversion therapy, an item called 'provocative therapy', another item called 'daily-living psychotherapy', etc. Some of the items were more sensible, but I became concerned principally with respect to two issues:

(a) It is well known that such a computer system will both educate and structure the thinking of its users. I would hate to think about my GP colleagues as experts in five different versions of aversion therapy
(b) I would have hoped that with increased computerisation the NHS management would also worry about interfaces between GPs' patient administration systems and the specialist patient administration systems. Ideally such an interface should exist and allow for direct transfer of referral letters by way of fax machines. I would further find it difficult to take a referral from a GP for 'provocative therapy'.*

For me, the need for a clear line from the College on patient administration systems, which would provide a solid basis for the negotiation of a sensible interface with the GPs' patient administration system, is obvious. It would appear that it should be a priority of the College to develop guidelines for such a system, as a good patient administration system could eventually provide information which can radically change the planning of services in the future.

Psychiatrists in the district of Liverpool have adopted a statement of 'user requirements for psychiatric and ECT patients' which would provide a good basis for such a discussion.

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*This statement does not imply a principle criticism of Farrelly & Brandsma's creative and entertaining book on provocative therapy, published in 1974 by Meadow Publications, Cupertino, California.

Mental Health Review Tribunals

DEAR SIRS

As a medical member of a Tribunal for some 16 years, I was saddened to note Dr Heaton-Ward's (*Psychiatric Bulletin*, August 1988) and Dr A. H. D. Hunter's (*Psychiatric Bulletin*, March 1989) comments about the dress of RMOs (presumably only male) when giving evidence at tribunal hearings.

Our lawyer colleagues, including both the President and the patient's representative, sometimes have the tendency to allow the pomposity of the court room to creep into the proceedings, possibly because of their unfamiliarity with the more relaxed atmosphere of a hospital. I consider it the duty of the medical member (hopefully with the help of the lay member) to try and humanise the proceedings. Although I favour a fairly formal style of dress for myself, both when I sit as a member or give evidence