STANTON, M. D. (1978) Some outcome results and aspects of structural family therapy with drug addicts. In *A Multicultural View of Drug Abuse* (eds. D. Smith, S. Anderson, M. Buxton, T. Chung, N. Gottlieb & W. Harvey). Cambridge, MA: Schenkman.

The responsibility of the child and adolescent psychiatrist in multidisciplinary teams

DEAR SIRS

We read this document (*Psychiatric Bulletin*, September 1989, **13**, 521) with some surprise, and at times disbelief. It is quite reasonable for health authorities within which we work to be informed of practices which depart from the strictly traditional, specialist service model, although one suspects that child psychiatry is not the only specialty to operate in the described way; other community based specialties must be operating in similar fashion. It is, however, true to say that child psychiatry, since its inception, has been blessed with the opportunity to draw in workers from a number of agencies, which allowed it to operate the most definitive, holisitic philosophy medicine has yet attempted.

There are at least two points in the document with which we felt we had to take issue. The first comes in paragraph (2) – yes, we certainly should make certain that mistaken assumptions that a child has been health evaluated are not allowed, yet it must also be made quite clear that the service is problem orientated and not a medical screening facility.

The most surprising statement is contained in paragraph (5) of the document, which appears to suggest that clinical responsibility cannot be terminated at the end of useful input by a specialist unless the general practitioner is in agreement. This has never been the practice of medicine. Instead, overall health responsibility passes back to general practitioners at the moment of discharge of an in-patient, while in the case of out-patients it never leaves the general practitioner; in this latter case, specialist input is terminated at the specialist's discretion. One has to assume that what appears in the paragraph is simply a matter of an unfortunate choice of words, since otherwise the authors of the document would have been attempting a complete re-write of the relationship between primary and secondary care, which we cannot believe could have ever been their intent.

Finally, we feel that it would be essential to stress that the mode of practice fostered by child psychiatry has allowed significant input to such areas as child abuse, fostering, child care, and education, which would not have been possible if child psychiatrists were to operate strict "medical" or "responsibilistic" attitudes; such approaches could hardly be defended as being in the best interests of our patients, which is the guiding principle of correct clinical practice.

THE LEICESTERSHIRE CHILD PSYCHIATRISTS

The arguments and positions made in this response have also been discussed and endorsed at a meeting of the Trent Regional Child and Adolescent Psychiatrists Group on 6 October 1989, who also expressed dismay that a document which could significantly influence the ways we work, appeared in the *Bulletin* with the stamp of Council Approval, but without the wider membership having been given the opportunity to express opinion.

Mental health evaluation in the 'community'

DEAR SIRS

The Commission of the European Communities (CEC) through the Concerted Action Committee on Health Services Research (COMAC–HSR) in July 1988 agreed to sponsor a three year study of evaluation in CEC member states of the transition from mental hospital to extra-mural care of the mentally ill.

The study will ascertain the current state and development of mental health care, policy and legislation in member states. It will assemble available statistical data relating to mental hospitals, psychiatric units in general hospitals and alternative ambulatory facilities. The role and contribution of primary health care services in mental health care will be determined with special reference to chronic and disabling mental disorders.

National data have been collected and collated thus far from Belgium, Ireland, the Federal Republic of Germany and from England and Wales. From this small sample there are already apparent several models of transition from hospital to community care dependent upon different government policies, differing methods of financial resourcing and differences in the availability of personnel.

As has been experienced in previous international collaborative studies of mental health care, national data collection is often unreliable, unrewarding and fraught with problems of interpretation and comparison. The CEC study, like others before, will focus attention therefore on field studies within a comprehensive mental health service which wholly serves a defined population to be undertaken in a number of member states. During 1990 representatives from centres in the 12 CEC member states, with prior commitment to, and experience of, evaluation studies of mental health care, will prepare a project proposal for a Concerted Action Programme, the aim of which will be to produce from cumulative statistical data and from field studies, both a quantified assessment of the present situation of need for mental health care and an evaluation of the relative

merits of hospital and community care for the mentally ill. A Concerted Action Programme is a method of support adopted by CEC whereby the CEC undertakes to pay the costs of coordination and of bringing together researchers from various countries while the actual research is paid for and executed by each country.

The planning group concerned with the development of the study proposals included:

Dr Andre Baert, Brussels, Belgium
Professor J. Casselman, Leuven, Belgium
Professor C. L. Cazzullo, Milan, Italy
Dr Jose Sampaio Faria, Copenhagen, Denmark
Professor T. J. Fahy, Galway, Eire
Professor R. Giel, Groningen, Netherlands
Professor H. Hafner, Mannheim, Federal Republic of Germany
Dr J. H. Henderson, Northampton, UK
Professor I. Pelc, Brussels, Belgium
Professor M. Shepherd, London, UK.

The current programme of the CEC Medical and Health Research Committee is the fourth of a series and is being carried out during the years 1987 to 1991. CEC action on health services research in general and in the field of mental health in particular has gained support and favour only during this fourth programme. Major areas of concerted action projects at present include research on cancer prevention, infections in intensive care units and health status assessment in chronic and disabling medical conditions. Research is being conducted on systems of health care delivery, including perinatal care delivery, care delivery for the elderly, primary health care delivery and its interfaces and care delivery for the brain damaged following head injury. Research is supported also on health care organisation which includes activities on cost containment in health care, on health information systems, on the use of DRG to support hospital management and on economic aspects of AIDS.

Health technology assessment is another area of health services research which includes at present the analysis of regional variations in the use of health technologies, quality assurance in health care, legal aspects of medical devices and cost effectiveness of antenatal screening by ultrasound.

The advent of a mental health study in the CEC fourth programme of Medical and Health Research is to be welcomed and will provide an important contribution of knowledge and fact to policy makers, administrators and clinicians on a topical policy movement for which relatively few evaluative studies exist at present.

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Court requests for psychiatric medical reports

DEAR SIRS

Psychiatric medical reports are often requested by the courts either as part of the evidence for the trial of the alleged offender, or between conviction and sentencing. Often these requests reach the psychiatrist via the Probation Service and many of these requests are to see the alleged offender as an out-patient. Sometimes an assessment in prison is requested. Four out of five individuals for an out-patient assessment failed to attend and the fifth individual initially attended, but failed to attend for follow-up appointments after the court case was over. This non-attendance figure is considerably higher than reports of 20–57% psychiatric out-patients failing to keep their appointments (Baekland & Lundwall, 1975; Shah & Lynch, 1989).

As the courts are requesting a medical report it would be in the interest of the alleged offender to attend. Several factors have been reported with the associated non-attendance (Baekland & Lundwall, 1975; Frankel *et al*, 1989): younger age, difficulty of getting time off work, short notice of appointment, and insufficient information about appointment (Frankel *et al*, 1989). All these factors could apply to the above patients.

The contents of the report may have an important bearing on the individual's case and one wonders whether there should be an obligation on the part of the courts, or the Probation Service, to ensure that the psychiatrist has access to the individual. It would also ensure a more effective and efficient use of the psychiatric out-patient clinics in the Health Service. Sometimes this is achieved by the psychiatrist visiting the patient in prison. However, the problem arises where the alleged offence is not serious enough to require prison and perhaps a mechanism should be instituted whereby the psychiatrist has ready access to see individuals.

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References

BAEKLAND, F. & LUNDWALL, L. (1975) Dropping out of treatment. A critical review. *Psychological Bulletin*, **82**, 738–783.

FRANKEL, S., FARROW, A. & WEST, R. (1989) Non-attendance or non-invitation? A case-control study of failed out-patient appointments. *British Medical Journal*, **298**, 1343–1345.

SHAH, A. K. & LYNCH, S. (1989) *Characteristics of patients in a psychiatric follow up clinic*. Paper presented at the Spring meeting of the Royal College of Psychiatrists 1989.