does Section 139 give to psychiatrists, as individuals, in everyday practice?

In a recent judgment by Judge Henry in the case of *Furber v. Kratter* the protection from litigation for those implementing the Act may be less than first appears. Furber was an in-patient in Moss Side Special Hospital when she attacked a nurse in a vicious and unprovoked manner. The event was witnessed by Dr Kratter. Furber was placed in a seclusion room for 16 days as a result of her disturbed behaviour. She asked the High Court for leave to commence proceedings for negligence; which in law she would be required to prove that the event had caused temporary or permanent physical or mental injury. She also asked leave to commence proceedings for false imprisonment; which would require, in the setting of a detained patient in a Special Hospital, to show that she was held in unacceptable conditions of detention.

In his judgment Judge Henry referred to *Winch v. Jones* (1986) which looked at the purpose of Section 139 and the reasons why a statement of claim by a patient should be struck out. He decided that a patient who was asking leave under this Section does not need a stronger claim than would be ordinarily required. The Section was to protect against the possibility of a mental patient making wild or exaggerated allegations which are eventually found to be baseless. However, on the other side of the coin, it was appreciated that mental patients are more vulnerable than the general population to exploitation or abuse. Lord Justice Parker stated that the purpose of Section 139 was to prevent persons being exposed to or harassed by clearly hopeless actions. The test to apply for leave of the High Court "is not a trial of the documents and nor is it in any way a dress rehearsal of the strengths and weakness of the action. It is instead a relatively wide meshed sieve through which claims are processed, and many claims may properly get through it even though the judge granting leave may think that the claim at the end of the day may fail". He should only refuse leave of the action if it is unfair to the defendants. Section 139 refers to proceedings rather than the individual causes of action which in the case of *Furber v. Kratter* were overlapping. There may be occasions when leave is granted for one proceeding but not another.

The result of this judgment shows that the Section 139 gives very little immunity from prosecution even if the actions were performed in apparent good faith and with apparent reasonable care. The section appears to protect doctors only from wilful or exaggerated claims by detained patients but it does not provide any greater degree of protection.

M. W. D. ROWLANDS

Hackney Hospital
London E9

References

Furber v. Kratter (1988) QB CO559.
Winch v. Jones (1986) 1 QB 296.

Section 136 of the Mental Health Act

DEAR SIRS

I read with interest Dr Wallis's account on the Royal Society of Health dealing with Section 136 of the Mental Health Act (*Psychiatric Bulletin*, March 1989, **13**, 144–147). I would like to concur with Professor Bluglass's reported statement that Section 136 is used outside London and, indeed, its high rate of usage in a rural area has been documented (Fahy *et al*, 1987).

A colleague and I are currently looking at the converse of this situation, i.e. how an area with a below average usage of Section 136 deals with community psychiatric emergencies.

DONALD BERMINGHAM

Hinchingbrooke Hospital, Huntingdon and
Fulbourn Hospital, Cambridge

Reference

FAHY, T. A., BERMINGHAM, D. & DUNN, J. (1987) Police admissions to psychiatric hospitals, a challenge to community psychiatry? *Medicine, Science and the Law*, 27 October (4N), 263–268.

*Training in community psychiatry**

DEAR SIRS

The move to community based care has been widespread, and is not likely to reverse. It exposes psychiatrists to an experience often very different from that gained in a traditional mental hospital training. Established psychiatrists have adapted their practice to encompass current ideas, but training has been slower to adapt to the changing educational requirements of juniors, who will spend much of their working lives in such a system. Connolly & Marks (1989) have begun the debate on types of training for community care, and have produced a long list of areas in which they believe knowledge to be required.

It is prudent to look at the experience of those for whom the practice of community-based psychiatry is long established. In the United States there are several training programmes in community work. One of the longest established, at the Johns Hopkins

*Based on a talk given at the Scottish Trainee's Day, Royal Edinburgh Hospital, March 1989.

https://doi.org/10.1192/pb.13.7.378-a Published online by Cambridge University Press

Hospital in Baltimore, includes a two year secondment with both academic training and clinical attachments and the opportunity to undertake a related research project. While perhaps ideal, this does not seem an appropriate model for training within the confines of the NHS. In the United Kingdom the experience at Dingleton Hospital, in the Scottish Borders, offers a more direct insight into the problems liable to be encountered in service-oriented training within the Health Service. They have found difficulties in several areas, including isolation experienced by trainees and some difficulty in role-differentiation in multidisciplinary teams (Jones, 1988).

A Collegiate Trainees' Committee Working Party examined the problem in 1987, and concluded that "The introduction of a community orientation to the teaching of adult general psychiatry should be a priority for clinical tutors, scheme organisers and consultant trainers" (Scott & Webb, 1987). This report, and that by Connolly & Marks, identifies a bewildering number of areas in which the trainee should become competent. We would suggest that despite different resources and methods of working, there exist 'core features' common to all community practice. These make it possible to set out objectives to be met in any type of community experience.

Registrar training objectives

Junior trainees require experience in the following areas:

Settings

Trainees need to develop the ability to work in all resources that treat and support patients and their families. These include:

(a) in-patient facilities
(b) community settings: day hospital; health centre; SW/local authority day centres; voluntary agencies; homes of patients and relatives; and hostels and other residential facilities.

Work in such settings requires the development of specific liaison and counselling skills, including techniques of crisis intervention and group and family therapy. It is necessary to develop an awareness of both the pitfalls and advantages of links with other agencies. This requires good supervision.

People

Trainees need to learn how to function effectively within multidisciplinary teams. They have to be able to move into the territory of other disciplines, and to work within the hierarchies encountered. While becoming able to collaborate with other disciplines, they have to be helped to retain their basic clinical skills. Often trainees feel they are valued only as teams' prescription writers. Models of multidisciplinary working should offer a balance between common and special skills, allowing them to function as full members of teams.

Research

Research is an area which can suffer in the demands of a community-based placement. It is important that this is avoided, and trainees are helped to pursue research interests actively. Specific skills are required in order to plan and evaluate a community psychiatric service. Planning requires the ability to assess local psychiatric morbidity for the purpose of gauging appropriate levels of service provision. Evaluation will play a vital role in acquiring and maintaining resources. In the community, research cannot be regarded as a luxury: it should be an integral part of working practice. To achieve this, the trainee increasingly requires knowledge of basic research methodology and specific epidemiological skills.

Peer group

There are obvious disadvantages in working in the community in isolation from the peer group. Trainees have to be helped to:

(a) develop skills in maintaining links with their peer group
(b) have access to a high standard of continuing education at different sites
(c) develop access to good library facilities.

These tasks require the allocation of specific time slots. Trainees often feel this is a part of their timetable which can be compressed if clinical commitments are pressing; it is the responsibility of their supervisor to encourage them not to do so.

Administration

They must know how to maintain an administratively integrated service. This requires management skills, which may be enhanced by becoming observers on planning and management committees.

Connelly & Marks argue that boundaries between registrar and senior registrar training should be blurred. We would suggest that different, but complementary, types of experience are required at each stage. Junior trainees, while liable to have experience of general psychiatry and a grasp of psychopathology, are working in a community placement to enhance their existing skills and to acquire those in the areas described above. They need to work as part of an established team, with suitable support. There is a danger of junior trainees being left to work alone with inadequate supervision. It is necessary that time be set aside for detailed supervision of their case load and to provide the opportunity to discuss with a

https://doi.org/10.1192/pb.13.7.378-a Published online by Cambridge University Press

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.

DENISE COIA
CAMERON STARK

Florence Street Day Hospital
Gorbals, Glasgow

References

CONNOLLY, J. & MARKS, I. (1989) Community oriented psychiatric care. *Psychiatric Bulletin*, **13**, 26–27.

JONES, D. (1988) *Registrar Training in a Psychiatric Service with a Community Emphasis*. Unpublished Report.

SCOTT, J. & WEBB, T. (1987) *CTC Working Party Report: Training Implications of the Shift to Community-Orientated Psychiatric Practice*. Unpublished Report.

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.

N. H. WEIR

Milton Keynes General Hospital
Milton Keynes

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

https://doi.org/10.1192/pb.13.7.378-a Published online by Cambridge University Press