

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, holistic 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