purposes can be fulfilled without undermining their fundamental differences.

In relation to Dr Beckett's suggestion about identification by 'cheese-bite' it should be remembered that many substance misusers are edentulous by the age of 25–30!

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Health gain among psychiatric patients

Sir: The point made by Elisabeth Ashbridge and Steven Milne, concerning 'The Health of the Nation and suicide prevention', (*Psychiatric Bulletin*, February 1994, **18**, 110), is an important one. I would, however, suggest that the main reason that the Department of Health has placed such emphasis on a significant reduction in suicide rates by the year 2000, is simply that there is a lack of information about what, apart from surviving suicide, constitutes health gain for mentally ill people.

With this in mind, the University of Wales College of Medicine, School of Nursing Studies, has established a major research project throughout Wales, which is designed to measure not only the extent to which mentally ill people who are cared for and treated in the community, experience health gain, but also to assess the nature and composition of health gain.

This study will be replicated in Holland and elsewhere in Europe in order to produce comparative international data. A first report may be expected in January 1995. While the project will not necessarily serve to reduce suicide rates, it may throw light upon the behaviour characteristics and coping ability of those who commit suicide, compared with those who do not. More notably, it will serve to show that suicide is but one, and not necessarily the most important, aspect of health gain (or loss) among psychiatric patients in the community.

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Alternative uses for old hospitals

Sir: 'The Fire at Long Grove Hospital' (*Psychiatric Bulletin*, February 1994, **18**, 94–95) as reported by Henry Rollin indicts those responsible for the "wanton disregard paid to the security of an historic building" and must raise concerns in many parts of the world where major hospital closures have occurred.

In Western Australia, the first asylum to close did so in 1905, and continued in use for various purposes until now it forms the Fremantle Arts Centre. The Claremont Mental Hospital built in 1905 closed in 1985. The main core of the buildings has since remained derelict and vandalised. The architect was Charles Grainger, father of Percy, and responsible for many significant public buildings in Perth. Nevertheless 90% of his work at Claremont has been demolished, and land sold for housing. The government has recently agreed to fund restoration of the main hall and administrative buildings to develop a community centre. Fortunately the building has escaped the fate of Long Grove, but more by chance than design. In 1992 I visited the hospital in England where I trained as a psychiatric registrar in 1967, St John's, Stone, only to find it boarded up and unused.

It seems urgent that, if these buildings are to be preserved, not only as history, but as resources that the community may want to put better alternative uses, then feasible ideas and options need to be considered. This process could be facilitated if evidence exists of successful alternative uses.

Perhaps the loss of Long Grove might stimulate attention to ways of preserving these old buildings, not as mental hospitals, but as civic resources. Collaboration between architects, historians and psychiatrists could be a fruitful alternative to the sad photographs of Long Grove.

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'Quality in the Psychotherapy Service'

Sir: We recently discussed the paper by F. Denman (*Psychiatric Bulletin*, February 1994, **18**, 80–82) and, while we acknowledge the difficulties inherent in auditing psychiatric practice, and particularly in auditing psychotherapeutic practice, we wish to raise the following concerns.

Our major concern was that while the paper intended to pass as a "scientific analysis", it appeared subjective in the language used to describe the work in which value judgements were expressed. As an example, "sadly four therapists used no definitive interpretations" and "this is a disappointing figure, particularly because the rater's impression from listening to the tapes was that there were many communicative 'misfires' which could profitably have been investigated but which were left to lie". We were given no direct accounts of clinical material which would have helped to anchor the paper in clinical practice and to convince us of the subjective assessment of the raters.

The author seemed to be putting forward criteria by which to judge "good practice in cognitive

analytic therapy" without being explicit that these were agreed quality standards to be present in any practice of CAT. Furthermore, there seemed to be no agreed level of expertise expected of the therapists; however, the impression was given that implicit standards and practice were operating.

The link between supervision, (as would be practised in the normal course of good psychotherapy), and audit was not clarified. We were therefore left wondering if the analysis of audio tapes was routinely used as part of supervision or whether it has been introduced sporadically and specifically for the purpose of audit. No comment was made about the potential difficulties in audio taping therapy sessions, and its effect on the process of therapy.

We felt that this paper raised more questions than it answered. Our recommendation would be that it could have been more valuable as a descriptive account of the process of setting up this kind of audit of psychotherapy, acknowledging its limitations and difficulties, rather than the quasiscientific inquiry it became.

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Sir: On criticising my work Kerr *et al* raise issues of considerable importance in psychotherapy research. They take exception to what they see as subjective and evaluative judgments made in my audit, and presented in a "quasi-scientific" format, citing for example, the use of the term "definitive interpretations". This is odd as the term "definite" interpretations is closely defined (point 1 in Table 1). They also criticise a comment about "communicative misfires" even though this is clearly signposted as an impression.

The suggestion that clinical material should have been presented was prevented by space constraints although this would not guarantee greater objectivity because of biasing effects of selection, recall and description. Taping could eliminate some bias but Kerr *et al* have reservations about the effects of taping on therapy and take me to task for failing to discuss this. The matter does need discussion, most importantly in the area of ethical and practical criteria for gaining informed consent to taping in a way which respects psychodynamic and power issues. But in my experience the chief anxieties, problems and resistances to taping arise in the therapists not the patients.

I was sad my paper might have given the impression that supervision was not a regular, mandatory part of the practice of CAT and that the authors implied that the therapy done at Guy's was not good. Neither is true.

I was astonished that Kerr *et al* felt it a criticism that my paper raised more questions than it answered. I take this as an (unintended) compliment. The chief point of my paper was to report how (more by luck than by judgement) an audit I had done which had certain features did change practice (whether for the better remains to be evaluated). I suggested that success in this respect resulted from how our evaluations managed to be both close to and distant from the concerns of clinicians and supervisors. If this feature made for "quasiscience" then at least in audit terms it seems to have worked.

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The same old scene?

Sir: Lewis (1991) states having a publication (and not simply being involved in some research project) is important in getting to interview. Post-membership appears to be the optimum time for this as examinations no longer loom on the horizon.

Most books on research regard the process as starting with the formation of new hypotheses and then the subsequent generation of methods to test them. Flanigan (1992) showed that 14.9% of papers in the *British Journal of Psychiatry* had a junior author. This included the senior registrar grade. Lewis was concerned with the progression of registrars to the senior registrar grade. For registrars the situation is still poor: (excluding non-UK authors) there were 258 authors present in the January to June 1993 issues of the Journal. Of these 17 (6.5%) were registrars, and were almost (bar one) exclusively present in original papers (7 out of 158 – 4.4%) and brief reports (9 out of 44 – 20.4%). There were no papers of original research with sole authorship.

The trend is therefore unchanged for registrars. Since brief reports continue to be the only realistic, but still sparse, method of obtaining publication it shows that publication does not equate with research. If Lewis' hypothesis still holds then the determining factor for interview is not the generation of new hypotheses and testing them (pure research), nor really the testing of other professionals' ideas (passive research normally involving the laborious administration of innumerable rating scales), but is actually dependent on which patients you see. Essentially career progression is determined, not by having experience of seeing thousands of mentally ill and learning to manage them, but more by the one case of an Eskimo