GPs were asked whether, if they had a fixed budget to allocate for the care of their practice population, they would continue to refer patients with an alcohol problem to our services. Seventy-nine per cent of GPs (63/80) replied that they would continue to refer to these services, but if then given the choice between referring specifically to out-patient or in-patient services, or both, there was a further change in their behaviour. The proportion of GPs who would continue to use both in-patient and out-patient services fell to 51% (41/80). Twenty-five per cent of GPs (20/80) would prefer to use out-patient and day-hospital services only.

Nineteen per cent of GPs (15/80) said that, given a limited budget, they would no longer use the alcohol services. Of these GPs who said they would no longer refer alcohol patients: 20% (3/15) said they would prefer to use alternative health services for these patients; 20% (3/15) said they would prefer to manage the patients and any required drug treatment themselves; one practitioner declined to comment; but the clear majority (53% or 8/15) said they would prefer to use their cash-limited budget on other patients altogether.

There are methodological problems with this kind of postal survey; for instance, the views of GPs who currently do not refer to our services are unknown, and there are inherent assumptions about the nature of limited budgets and exactly how the contracts for care between primary care and hospital services will be arranged and paid for. The questions are necessarily generalised for not all GPs will be given a practice budget and not all local hospitals will become self-governing. However, the survey does indicate a trend that may form the shape of future health care provision. Taking a business-like point of view, as we are urged to do, a 19% fall in referrals (and hence turnover) from GPs who currently use the service (established customers) cannot be ignored. If GPs who do refer are allowed to specify what form of care they want then there would be a further decrease in the primary care uptake of in-patient alcohol services.

A limited budget is obviously going to be a crucial determining factor in referral behaviour, and much must depend upon the exact size of the budget. If there is a surplus in the budget then presumably there will be less pressure to discriminate between treatments and patients. The White Paper suggests that for the internal market to work though there must be limits to this budget. The Department of Health has proposed an annual practice budget of £600,000–700,000 for about 11,000 patients. This survey suggests that GPs may discriminate between patients as far as the use of their budget is concerned. This has implications for alcohol services and patients with alcohol problems. Whether these implications include an improvement in the quality and delivery of care to these patients is doubtful.

If there is a change in clinical practice towards patients with alcohol problems, then logically there must be changes in clinical practice towards other diagnostic groups. The extent, nature and consequences of these important changes are currently unknown.

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Family therapy – the need for research

DEAR SIRS

Despite the initial resistance in turning our attention from individual to systems therapy, the family therapy movement has grown rapidly over the years. Now numerous well established centres exist on both sides of the Atlantic and teaching and practice of the different family therapy models is widespread. But while there has been an enormous increase in the number of studies in the field of family therapy outcome (Gurman & Kniskern, 1978), there is a continuing need for more. Questions that a therapist in the field of family therapy may ask at some point during his/her training are:

(a) What school of family therapy should I gain experience in? Some models are favoured by family therapists with a particular personality. However, as clinicians we should be asking questions such as "Which model of family therapy is the most efficient and most applicable to the type of work that we are engaged in?" Unfortunately there is a lack of research evidence to decide on an answer to this question. Perhaps it is wise to experience as many as possible before concentrating on one specific approach/model. However, there is evidence that structural family therapy should be considered a family therapy treatment of choice for childhood psychosomatic conditions such as anorexia and others (Minuchin *et al*, 1975) and in the treatment of drug addiction (Stanton, 1978). Properly orientated

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behavioural family therapy appears effective in the treatment of childhood behaviour problems such as aggressiveness (Patterson, 1976).

(b) Which courses in family therapy are the most useful to attend? There are many in this country (mostly concentrated in London) but they vary widely as to demand for time needed to attend and magnitude of course fees which can be considerable. Some courses are well established while others have just started. The therapist has to convince his employer that what is gained from the course will be applicable and helpful to the work carried out at base. A lot is learnt from the other people participating on the course and their experiences give useful insight as to their approach to problems with families. A group that is willing to work and share gives valuable support and knowledge to therapists. Groups larger than six people probably do not provide much of an opportunity to share worries as it takes too long to build trust among members.

(c) How to teach family therapy to colleagues? Some places have courses to train supervisors and people usually graduate to these after completing the training course. However, most of us are simultaneously trainees and trainers and this dual role provides a smoother transition to the role of supervisor or trainer. In individual psychotherapy the emphasis is on supervision, either individually or in groups, and for a "training analysis". Family therapy can also be taught and supervised individually or in groups. The one-way mirror has added an *in vivo* quality to supervision and an opportunity for the supervisory group to participate in therapy and video is an excellent method of supervising and teaching family therapy. Some centres use live supervision and instant feedback. Occasionally a family therapist may work on his/her own because of self employment or the type of work engaged in. This must be an enormous burden of responsibility and one is all too aware that families can occasionally be damaging to professionals. Some of these solitary therapists attend courses for support and direction.

(d) What do my colleagues think of family therapy? Gaining experience in family therapy is one thing, but to apply it in the setting that one works is another. We must remember that family therapy is relatively young in the field of child psychiatry. It is therefore important to develop ideas of ways of working that are responsive to that setting and arise from within that system if one is to be accepted. Many professionals will confess that they see families but would not say that they are practising 'family therapy'.

(e) Family therapy research? There remains a paucity of good quality sustained research. Have we the courage and skill to evaluate the limitations and failures of our therapies? There is a need to teach good research skills to clinicians and an increased collaboration between family clinicians and researchers to facilitate the applicability of family therapy research findings. We should be moving away from traditional emphasis on outcome research and towards exploratory research and developing new methods of gathering data. An attempt must be made to improve our understanding of the mechanism of therapeutic change:

  (i) We need to study the common effective elements and mechanisms of change.

  (ii) We need to study the practice of family therapy in combination with drug interventions or other psychotherapy interventions.

  (iii) The study of the factors resulting in negative therapeutic affects and family therapy failures (Coleman, 1985).

  (iv) The study of family therapy with primary relational disorders such as violence, divorce, re-marriage which should be compared to family therapy treatment focusing on individual disorders for which there exists evidence that non-family treatments are effective such as cognitive therapy of depression, exposure treatment of phobias.

  (v) Research to study the effect of non-family therapy on the family such as an individual therapy on patient's marriages and on relationships with their children.

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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

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