



the columns

correspondence

Psychiatry and the media

We have read with interest Mark Salter's article on 'Psychiatry and the media: from pitfalls to possibilities' (*Psychiatric Bulletin*, April 2003, **27**, 123–125).

It is very relevant to the developing world in the sense that both the print and electronic media can be powerful tools to either perpetuate or dispel the many myths surrounding mental illness that particularly abound in our cultures. A case also in point, is that suicide and attempted suicide rates have been high in Sri Lanka over the past few years (World Health Organization, 2001), and the media reports of the events have, most of the time, been a gross misrepresentation of the facts and have sacrificed truth at the altar of sensationalism. The sociopolitical events associated with the event are brought to the forefront, and the underlying depressive or other psychiatric disorder directly contributing is often ignored.

Against this backdrop, psychiatrists in the developing world should re-think their role *vis-à-vis* the media. We cannot confine ourselves to the comfort of our clinical settings. If the populace is to be educated regarding psychiatric illnesses, their identification, prevention and treatment, the information we wish to disseminate will have to be packaged in a 'news-worthy' form. Only then will the content be noticed and acknowledged. As mentioned by Salter, the 'tele-dramas', the local soap operas, could be used effectively to reach the minds of the people in a culturally acceptable and media friendly form.

WORLD HEALTH ORGANIZATION (2001) *Suicide Prevention: Emerging from Darkness*. Geneva: WHO.

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Pre-registration posts in psychiatry

I was intrigued to read the article by Herzberg and colleagues about pre-registration posts in psychiatry (*Psychiatric Bulletin*, **27**, 192–194). It was I who established the Sheffield rotations in 1981, as described by Jane O'Dwyer. It was a fortunate time because there were extra house officers requiring posts, so two pairs of far-sighted physicians and surgeons who had extra posts agreed to include the second one into the experimental scheme of four monthly rotations in medicine, surgery and psychiatry at the Northern General Hospital, Sheffield.

The issue that worried me about these rotations was that while many psychiatrists praised the idea, no one ever copied it. I began to wonder whether I had introduced a group of Sheffield graduates to a life fraught with difficulties as they tried to live down the disgrace of their pre-registration. Luckily, I have just received evidence to the contrary.

With six doctors a year for over 20 years, it is perhaps not statistically surprising that on the day I received the *Bulletin*, I also received an invitation to attend the Inaugural Lecture to be delivered by Professor Tony Avery, Head of Division of Primary Care at the University of Nottingham. Tony was in one of the earliest rotations.

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Money for mental health care in 2003/4

Glover (*Psychiatric Bulletin*, April 2003, **27**, 126–129) has served patients well,

delineating the failure of the Department of Health to instruct the Primary Care Trusts to finance the National Service Framework documents. May I suggest a minimum compulsory target of 15% for urban areas, and 11% elsewhere, to be achieved within 5 years? A sector basis for distribution would be the Mental Health Needs Index (MINI; Glover, 1998). This index, most successful for urban areas, originated in NE Thames, and can be calculated on an electoral ward basis by a programme from Glover, and gives numbers needed for acute and psychiatric intensive care unit beds, as well as community 24 hour nursed homes, and other supported accommodation. The latter are vital, as the 40–50% homeless in-patients of the under-funded Tower Hamlets testify (Turner & Priebe, 2003).

Personally, I doubt if a reasonably civilised service can be provided on less than £1 X MINI per capita per annum. A simpler measure is a district count of the number of residents (including homeless and hostel residents) known to have suffered with schizophrenia, though they may be temporarily out of contact with services. This group is most likely to cost long-term money, and its needs are recognised in the calculation of a 20% spend in the long-stay belt of the former Epsom hospitals, whose patients came from all over London. The lowest spend of 8% in East Devon is made up for by the 15% spend in Exeter, where the ex long-stay residents from all over Devon were resettled.

GLOVER, G., ROBIN, E., EMAMI, J., *et al* (1998) A needs index for mental health care (MINI). *Social Psychiatry and Psychiatric Epidemiology*, **33**, 89–96.

TURNER, T. & PRIEBE, S. (2003) Forget community care – reinstitutionalisation is here. Letter. *British Journal of Psychiatry*, **181**, 253.

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