and though initially regarded as somewhat of a curiosity, I am gradually getting to know people in the department and becoming involved in their work. The range of duties in my main hospital is broadly similar to that of the full-time senior registrar, and inevitably work spills over into one's own time, as one would expect it to do.

A year into higher psychiatric training I am able to look back at the 'part time' problem. There has been endless debate about the rights and wrongs of devoting one's time as a medically trained woman exclusively to one's family or, alternatively, concentrating on one's career and transferring other responsibilities to someone else. Most women—and most part-time trainees are women—must make an individual choice and some, like me, will decide on what may seem to many to be an unsatisfactory compromise. On a personal level one needs determination, knowledge of what arrangements are available, and above all support and encouragement from family and colleagues. The actual organization of the job has created few problems apart from the extra load placed on my colleagues during periods of absence and annual and study leave. From the opposite viewpoint, though, I have been able to help with the work when I have been there, as my post has been surplus to establishment.

As far as the training is concerned, as a registrar I experienced all aspects of the job as do the full-time trainees. I found the studying difficult, but this is not exclusive to part-time trainees. I was not prepared for the problems and anxieties surrounding the application for a senior registrar post, and found the struggles to arrange this the most daunting of all.

I would have welcomed contact with someone else training in the same way for discussion of difficulties and support. The various articles published in the journals were useful sources of advice, although some were written from a very unsympathetic standpoint!

My domestic commitments have gradually changed in character over the years as my children have become more independent, but I am still geographically tied. When the time comes to apply for a consultant post I would now feel able to offer a full-time commitment to the specialty. In spite of its drawbacks, part-time training has been valuable to me during the time I have needed it. The scheme is a good one, but whether it will survive in the face of rumoured medical unemployment and financial stringencies remains to be seen. If it does not, the choice facing today's increasing numbers of female medical graduates will be even more stark than at present.

Psychiatric Advisory Service—Statement of Need

T. J. FAHY, Vice Chairman, Irish Division and Chairman, Irish Psychiatric Association

The Irish Division, through its Executive Committee, is pursuing a policy of pressing for early consultation with the Department of Health on Irish national issues bearing directly on the welfare of the mentally ill. Part of this policy is to publish from time to time selected position papers of significance which have been submitted to the Department. The following paper advocates the monitoring of psychiatric services in the Republic of Ireland by peer review with tentative suggestions as to how this might be achieved. In a slightly different form this paper was submitted to the Department of Health in March 1983 without, to date, formal response.

Until recently, civic visiting committees and Department of Health Inspectorates have served as safeguards of good standards of care for the mentally ill in the Republic of Ireland. However, standards in some Irish psychiatric services were noted to be poor in the College's approval exercise. Even new legislation now pending does not provide any further safeguard other than against unfair detention. A new approach is needed which will safeguard standards and will command the confidence of the caring professions and of the public at large.

All professions traditionally are self-monitoring, but ordinary professional discipline is inadequate for this purpose in relation to psychiatry for several reasons:

(1) Psychiatric procedures are based on a wide range of techniques of intervention and accommodate a wide variety of behaviours, both in the doctor and in the patient. This variety makes it difficult for the consumer to know good from bad practice.

(2) Psychiatric patients are sometimes irrational and may be compulsorily detained for treatment; they are thus badly placed to monitor their doctors compared with other medical patients.

(3) With few exceptions, Irish psychiatric facilities are isolated from general medical care. There is a consequent tendency for practice to become idiosyncratic and eccentric. This tendency is aggravated by lack of knowledge as to the best way to proceed, particularly in community settings.

These points are well illustrated in recent British experience of statutory inquiries, fire scandals and maltreatment of

https://doi.org/10.1192/S0140078900010841 Published online by Cambridge University Press

mentally abnormal offenders in Special Hospitals. These occurrences have led to increased public awareness of civil rights for the mentally ill and may have contributed to the foundation in 1970 of the Hospital Advisory Service, subsequently re-named in 1976, the Health Advisory Service. The latter is a system of monitoring services by multidisciplinary peer review.

The Irish Psychiatric Association (i.e. those members of the Executive Committee of the Irish Division who work in the Republic of Ireland) considers that the most appropriate method of monitoring psychiatric services in the Republic of Ireland would be by 'multidisciplinary peer review.'

Catchmented area services need information, encouragement and the opportunity for comparison with other services. The personnel providing this kind of stimulus should be representative of the disciplines most cognate with psychiatry, such as nursing, social work, clinical psychology and health administration.

In considering possible administrative structure, it seems that a director and secretariat are basic. The director should be a consultant psychiatrist with experience of Irish psychiatric hospital services. A permanent appointment should probably be avoided.

The appointee could be seconded for a term of, say, three years and facilitated in continuing professional practice on a sessional basis during the term of office. A team of collaborators might be assembled by seeking nominations from cognate professional bodies. The basic field technique might consist of on site visits by a small team to individual health board services. Services within health board areas would be visited before moving on to another area. The guiding principle would be to improve patient care in individual hospitals and area services (excluding matters of individual clinical judgement) and in the psychiatric service as a whole. Visiting teams might consist of a consultant (usually the director), a psychiatric nurse, an administrator and a social worker. Other specialists might be required from time to time. These personnel would be available on secondment for about one week and should, as a rule, come from health board areas some distance from the service being visited. There would be need for preliminary training for visitors who might go on Health Advisory Services visits in the United Kingdom or on Joint Accreditation Board visits in the USA.

Funding

Funding of field visits might be provided by the health boards being visited.

Accountability

Any monitoring service should be seen to possess a definite spirit of independence if it is to maintain credibility with the caring professionals who operate psychiatric services. Strong research obligations should be present from the outset. Accountability thus would be: (i) to the staff and administration of individual services and health boards by confidential joint reports following on site visits; (ii) to the Department of Health by direct report of the director; (iii) to the cognate caring professions by the reports of professional participants in the monitoring service; and (iv) to the general public by agreed public reports on services and by periodic research reports.

Conclusion

Psychiatric services in the Republic of Ireland need a well thought out scheme of monitoring by peer review which will safeguard standards of care and which will be acceptable to the patients, the public and the caring professions. Irish psychiatrists are well placed to initiate such a service by virtue of their experience in peer review schemes conducted by the Royal College of Psychiatrists since its foundation in 1972. Examples include the College Approval Exercise and the accreditation procedures of the Joint Committee on Higher Psychiatric Training and the Irish Psychiatric Training Committee, and finally 'audit' type surveys such as those of ECT in Great Britain[1] and the Republic of Ireland (Latey and Fahy, in preparation).

REFERENCE

[1]PIPPARD, J. & ELLAM, L. (1981) Electroconvulsive treatment in Great Britain: A report to the College. *British Journal of Psychiatry*, **139**, 563–8.

Responsibilities of the Consultant Psychiatrist in relation to Sections 2, 3 and 4 of the Mental Health Act

At a recent meeting of Council a Resolution concerning consultant responsibility and the Mental Health Act 1983 was discussed. Concern was expressed that although the College had recommended that approved doctors should have the Membership or its equivalent, difficulties were sometimes encountered in securing the services of doctors approved under Section 12 of the Mental Health Act. The following Resolution was therefore put to the vote and was carried by a considerable majority:

> The Council believes that it should become part of the responsibilities of the consultant psychiatrist in the Health Service to take part in organizing cover for Sections 2, 3 and 4 of the Mental Health Act 1983. This would normally be implemented after consultation with the Health Authorities and Social Services Departments.