description by each team member as well as by the author, who was in charge of research and development. The headings under which the assessment procedure was carried out are listed in detail. Some problems could be quantified, as in the case of the lady who screamed a good deal (baseline: 102 screams in a 2-hour period); the lady who banged on the table; the lady whose knees were stiff; the lady who needed a hearing aid; the lady with untreated diabetes, and the lady with unrecognised parkinsonism associated with a recognised dementia. Examples are given to illustrate the success of care in such cases.

The principles involved in 'single case experiments' are well known. In general, it is difficult to standardise the procedures in order to make comparisons. The demonstrable results (as in the examples mentioned above) come from undoing past neglect. Maintaining improvement is just as important but less easy to measure.

The authors therefore had problems with quantifying their system and provide no scales or statistics. They do not provide references to quantitative research into similar projects from the 1950s to TAPS, nor mention clinical audit, perhaps because they do not seem to know the highly relevant psychiatric literature. They do, however, cite a few of the excellent social work studies (with which psychiatrists should be more familiar) and correctly point out that the creation of mental health information systems should make routine evaluation easier.

Apart from its heartening illustration of the resource and energy with which people can tackle difficult problems when starting, as they think, from scratch, the booklet illustrates two sadder facts. The real skills and real knowledge acquired during the early postwar reform period in the best mental hospitals has only rarely been handed on to the present generation of carers, whether in residential or in non-residential settings. And the ideological and administrative divide that opened between the health and social services after the Seebohm Report seems as difficult to bridge as ever, on the brink of transfer of responsibility for community care from one to the other.

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The Royal College of Physicians of Edinburgh: Continuing Medical Education for Trained Physicians. RCPE, 9 Queen Street, Edinburgh. 1992. Pp 14.

This is a very valuable succinct report on issues that will affect all practising doctors. Although directed at a non-psychiatric service, it is clearly of relevance to psychiatry and especially to those involved in the supervision of audit and postgraduate training.

The document neatly summarises the background and the reasons for continuing medical education (CME) becoming such a prominent issue. It is not surprising to find that this section overlaps considerably with the early sections of the report by the College working group on Continuing Medical Education (*Psychiatric Bulletin*, 1992, **15**, 711–715).

At first reading the document appears reassuring for current psychiatric practice. Many of the recommendations are already standard practice in psychiatric services, e.g. regular academic programmes including case conferences, journal clubs, audit meetings and regular College inspection visits. Repeat reading dissolves this cosy picture. It becomes increasingly clear that full implementation of the proposals could have profound effects on psychiatric practice.

The Physicians appear to be convinced of the need for mandatory rules on CME and propose tough penalties for failure to comply. These include loss of junior staff and imposing a temporary category of specialist accreditation until compliance was confirmed. Section 9 of their document cogently argues the case for this viewpoint and Section 13 acknowledges the resource implications. The College working group did not go so far in their recommendations but appear to have been thinking along similar lines. The systems proposed would require enormous additional manpower in order to free doctors to attend CME but also to run programmes, to conduct the individual assessments and to run the vetting and monitoring arrangements.

CME is clearly a good thing and will have an impact on all psychiatrists. It is now over a year since the report of the College working group was published and members of the College should make themselves aware of developments. The risk is clearly that mandatory rules will be introduced by default "within existing resources" and we all know what that means!

In summary, this report clearly demonstrates why CME is good for patients and doctors alike. Why then am I left with a clear picture of the big stick but without any sign of the carrot?

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Health Trends, Vol. 24, 2, 1992, Department of Health. HMSO. £2.80. (Annual subscription £10.80).

A review of health and social services for mentally disordered offenders and others requiring similar

services, under the chairmanship of Dr John Reed, published its final summary after a gestation period of exactly two years. A total of 276 recommendations were made but only one forms the basis of this review, namely that regional health authorities should regularly assess the needs of their residents for secure and non-secure hospital provision. In view of the proposed increase in spending on medium secure developments from £3 million in 1991/2 to £18 million in 1992/3, the assessment was limited to secure hospital provision.

The two papers by O'Grady *et al*, consist of such an assessment in Leeds. The first paper looks at the relative contributions of three tiers of secure hospital provision to the city's population, namely the local special care unit (SCU), the regional secure unit (RSU) and special hospitals (SH). Interestingly, there is no reference to the private sector which makes a substantial contribution to secure hospital provision in some parts of the country. Over a six month period all the patients admitted to the three levels of security were monitored. The SCU had by far the most admissions, 64 compared with five to the RSU and one to SH. Most of the SCU patients were referred from general psychiatric wards and the community, including police referrals, and only a minority were offender patients. None of the five RSU admissions came from the courts or prison, in contrast to the majority of admissions to the RSU from other parts of the northern region. There was little movement of patients between the SCU and RSU. The authors conclude that local units are required to meet the total need for secure hospital provision which cannot be met by the RSU alone. Implicit in their account is the view that the SCU is taking patients who should have gone to the RSU, particularly prison referrals.

The second paper attempts to assess the degree of unmet need for secure hospital beds in Leeds. Relevant statutory and voluntary staff working both in hospital and in the community, particularly among the homeless, were asked to identify individuals who might require secure hospital treatment but who had not received it, or for those already in hospital, whether they were appropriately placed. In addition all remands to prison for psychiatric reports over a six month period were monitored. Thus unmet need fell into two broad categories, those in the community or prison trying to get into a secure bed and those in secure provision who might be in the wrong tier. In the latter group the numbers were small; three psychotic patients with learning difficulties in SH should ideally have been transferred to a lower level of security; six cases were stuck in the RSU and SCU but they had accumulated over a five year period. Similarly of the 23 prison remands, two required and received admission to a secure bed and no absolute unmet need was identified.

The community survey revealed a very different picture. Sixty-nine cases were identified by their carers as requiring secure hospital provision although the researchers discounted 20 cases. Of the remaining 49 individuals, their unmet needs broadly consisted either of difficulty in access to statutory agencies, or a lack of stable, structured residential accommodation. The group as a whole tended to be disruptive, potentially violent recidivists living an itinerant lifestyle, often referred to as "rejecting and rejected".

Taken together these two papers show that surveys of unmet need will give very different results depending on where you look. In Leeds, there appears to be good liaison between prison and secure hospital and most patients are in the correct tier of hospital security. A need is identified for long term medium secure beds for a small number of patients, principally those with learning disabilities who have accumulated in the system. In the community, on the other hand, there is substantial unmet need for local secure hospital provision. Although the local SCU takes the vast majority of referrals to secure beds, it is this facility which is failing to meet the needs of the community and perhaps this is where the money should be spent.

The way forward would be for the SCU to shed its RSU-type role regarding offender patients and concentrate on responding rapidly to community referrals, particularly those which come through the police and the new court liaison schemes. It is notable that of the 49 individuals in the community who might require secure hospital admission, none had in fact been referred, perhaps a reflection of the carer's pessimism about the likely response. Currently, community workers soldier on until a crisis develops, often in the form of a criminal offence, and there is little statutory management which could be considered proactive. As the authors point out, there needs to be considerable inter-agency cooperation to meet the needs of this group, without which any hospital response will continue to be reactive and crisis-led.

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In a country the size of India, where caste, creed and class are important features for daily functioning, other social factors also play a significant role in the pathogenesis and prognosis of mental illness. Various international studies have established that