We must be careful not to throw out the baby with the bathwater. The normalisation principle is essentially a good one which has enhanced our perceptions of, and support offered to, disadvantaged individuals. There is a need to relate existing data on basic psychological processes to the phenomena which Dr Boucherat describes. Then, hopefully, we can start to bridge the gap between Wolfensberger's observation of, and ideals regarding, society, and Clifford's statement regarding the importance of the individual's internal world, his feelings, and his general state of mind.

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REFERENCE

[1]HEBB, J. (1946) On the nature of fear. *Psychological Review*, **53**, 259–275.

Planning for bed needs

DEAR SIRS

At some risk of being considered one of those doctors who hold entrenched positions, oppose necessary change and so on, I write in response to some of the points raised by 'Planning for Bed Needs and Resource Requirements in Acute Psychiatry' (S. R. Hirsch, *Bulletin*, December 1987, **11**, 398–407). It was a laudable attempt to address a serious and difficult practical problem but I doubt if it is meaningful to quantify the value to a psychiatric service, on the basis of any statistical data at present available.

It may be naive to expect it, but there seems to be very little mention of *quality* in this debate. Some discussion of what constitutes 'quality' might indeed help to raise the standards of communication between ourselves, the general public, the 'media' and our political representatives.

Meanwhile I am puzzled by the Working Party's choice of 'activity' as the proposed sole criterion of the functioning of an active psychiatric service (since 'resource provision' and 'potential demand' are not characteristic of the service, but of the conditions within which it must operate). Obviously it is of some interest to any employer to know that an employee is active rather than idle; but it is *useful* activity, not activity *per se*, which an intelligent employer wants to maximise; that is, activity which contributes to the stated goals of the organisation.

From this point of view, what is required is, firstly, to define the goals of the acute psychiatric service in question; these may well vary from one community to another and indeed, probably ought to do so, since there are likely to be *qualitative* differences in the nature of the demand and how it is expected to develop in the foreseeable future. The next rational step would be an attempt to devise some way of estimating, quantitatively how far each unit of a given type of activity *contributes to those goals*. This would make it possible to estimate the 'useful activity output' of the service in question. To obtain a meaningful estimate of efficiency, this quantity should be *divided* by the total activity, which might be estimated broadly along the lines suggested by the Working Party (but more on that subject later).

This approach would be roughly analogous to the way in which efficiency is defined in other spheres, as 'useful work done' divided by heat or energy or work put in. It would not conflict with the queuing-theory approach so lucidly advanced by Dr Marjot (same issue of *Bulletin*). With respect, it makes little sense to define efficiency as 'work put in by the service' divided by 'money put into the service'. If an economic measure similar to productivity is what is required, then it should be defined as '*useful* activity output' divided by 'money input'.

With these general principles in mind the suggested activity 'algorithm' (sic) seems to be at odds with any sort of community-orientated policy. The given formula implies that one patient admitted and discharged adds two points to the 'activity' score, whereas one domiciliary visit which prevents an inappropriate admission by mobilising other methods of support (such as CPN visits, which do not count!) adds only half a point. In other words—prevent an admission and you are penalised one and a half points. The weightings used in the formula seem to illustrate with exquisite aptness the point that *useful* activity—not aimless activity, not 'statistical' or fictional activity—is what a psychiatric service should be producing from its resources. Almost any formula will tell an interesting story—but some stories are more relevant than others.

I write in the earnest hope that the College will not allow itself to be drawn into supporting any further proposals for reorganisation, from no matter what ideological source, which do not rest on a basis of very well considered performance criteria.

HUGH B. G. THOMAS

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Professor Hirsch replies

DEAR SIRS

I agree with the overall direction of Dr Thomas' argument, and many of the points he makes, which are very important. It would be helpful if he and other readers interested in the subject would read the full report to get a better feel of the problem we are dealing with.

Ours is a report of what we are able to achieve with the limited amount of data painfully extracted pre-Körner while Dr Thomas' letter largely concerns itself with the direction in which the argument should continue to develop. Criticisms he makes apply equally well to the Körner data sets and the 'performance indicators' which the DHSS is currently developing. We were, in fact, completely unaware of the development of Körner until we finished our report, but they are both working on nearly the same lines.

It is the spirit of Dr Thomas' letter with which I have to disagree. It suffers from what I might call the 'reification fallacy'—a tendency to equate a measure of a thing to the whole of a thing, forgetting that it is only a measure. Our working party started out on the journey to try to identify how many beds, later redefined how great a resource, a district needs for its particular psychiatric service. We realised there was no absolute answer but that we could talk in comparative terms within the overall context of the Health

Service as it is now. We also discovered that it might be possible to identify the likely demand on psychiatric services from sociodemographic factors and that useful comparisons could be made between Districts in terms of the amount of total activity (energy spent or work done) of the service in comparison to the resources they have, and in comparison to the potential demand.

If there is very little going in the way of out-patients' admissions, DVs, day hospital visits, CPN visits, but there is a large resource then one may suspect that something is wrong and local managers can at least try to explain it. There may be perfectly good explanations, for example the work may be going into some other area of activity like psychotherapy and rehabilitation which is not being measured. Equally, if there are very low resources or very low activity in respect to a high potential demand, as we found in some Districts, then it points to the fact that the District has not adequately resourced their mental health service.

Dr Thomas' points are important ones, but the measures we have suggested are perhaps analogous to the IQ—it measures one aspect of functioning and it has useful purposes but it does not give an indication of the quality of the individual nor their likely success in work and examinations later in life. When one aspect of the IQ is discrepant with another it can indicate that something is wrong and needs to be examined more closely. One should not have to repeat that any type of statistics have to be used intelligently and for the purposes to which they are suited. Dr Thomas's worry is that our approach might be used to estimate the quality of the service or other factors which, of course, is not the intention.

There are real problems with the kind of algorithm we used and by no means do I think the weightings we have given to different aspects of the service are right. I think we were trying to achieve, in measuring activities, exactly what Dr Thomas says—a measure of the work done or energy expended, rather than the quality or usefulness of the work done. The latter has to do with efficacy and, as I stated in my paper, we did not attend to that particular issue. We also recognised that as the nature of psychiatric services changes and the shift of emphasis moves from the hospital to the community, it will be necessary to add new ways of measuring both the work done and its efficacy. In the meantime, the work around a psychiatric admission is much, much greater than the work which surrounds an individual CPN visit and the number of out-patient visits as a total represent a far greater amount of work than the amount of work done by a small number of CPNs in most catchment areas.

I would hope that our report will move others to take up these issues and try to develop better measures of efficacy as well as efficiency—indeed we are currently applying for grants which begin in this direction.

The points made in Dr Thomas' letter need to be said and I hope that he and others will begin to work in the directions that he has outlined.

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Training in psychotherapy

DEAR SIRS

Despite the College's many requirements for higher psychotherapy training, it could be argued that key elements are lacking without which no specialist training in therapy can be said to be adequate. This letter hopes to stimulate debate about these hiati. Some might consider it a counsel of perfection, but the ideas could in fact be built into many training programmes within a short time, given the will to do so. Among the main training requirements missing at present are:

(1) Systematic training, academic and clinical, in the *indications* for each type of psychotherapy and why each patient of trainees is selected for a given approach. Where possible this training should be in the light of the research evidence on efficacy and, where that is lacking, of well-detailed clinical experience. The therapeutic investment in trainees' patients may range from 10 to fully 250 sessions, yet trainees are insufficiently schooled in how to decide whether therapy should be long rather than brief, family or group rather than individual, dynamic rather than behavioural, etc. There are of course huge gaps in our knowledge about some of these issues but much is known that is not taught. Trainees' time is a precious but limited resource which they need to learn to deploy wisely; one patient having 250 sessions denies 25 other patients having 10 sessions each, a decision that is worthwhile at times but should be clearly justified.

(2) Systematic training, academic and clinical, in defining with most patients the *goals* of therapy at the outset and the *criteria* by which to judge their subsequent attainment, in rapidly *measuring* goal and criteria attainment at the start, at intervals during therapy, and at follow-up, and in relating such change to their clinical interventions. Trainees give this too little attention. The success of psychotherapy training in teaching trainees to help their patients cannot be adequately judged without ascertaining clinical change. The means to do this economically on a routine, not research, basis has been available for decades even in dynamic psychotherapy at the Tavistock.

(3) *Follow-up* of each patient for at least six months where possible to check the durability of changes ensuing from therapy. If properly planned for, follow-up should be feasible with most patients in a four-year training programme, but at present it is given little attention.

(4) Systematic academic training in the *epidemiological base* relevant to psychotherapy. At present trainees have a little knowledge gleaned from general psychiatry yet on becoming consultants will be expected to help plan psychotherapy services. Informed judgement requires sound epidemiological knowledge, much of which is available despite a lack of data on some key issues. The therapeutic emphasis on trainees' therapy for the minority of sufferers who attend hospital reflects insufficient time given to the bulk of problems amenable to brief psychotherapy which remain in primary care. Another instance of inattention to what is common and treatable is a general lack of experience in