

for targets and categories by statisticians and epidemiologists, documents such as the *Health of the Nation* report (Department of Health, 1992) and the literature and correspondence created in its wake, do little to investigate the real motives which impel someone to take his or her own life.

I do not think psychiatrists should be so easily satisfied to accept these frankly crude targets without qualification and without raising political points for discussion. The current moral and political climate engenders despair, and the loss of personal and family security, the impaired quality of existence and the erosion of the sense of conscious, authentic personal responsibility has led to a weariness of life for which remedy is not easily found. Weariness with life is an emotional and political problem which cannot be treated by less toxic anti-depressants in overdose, or easily set targets.

DEPARTMENT OF HEALTH (1992) *The Health of the Nation: strategy for health in England*. London: HMSO.
PRITCHARD, C. (1992) Is there a link between suicide in young men and unemployment? A comparison of the UK with other European Community countries. *British Journal of Psychiatry*, **160**, 750–756.

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Psychiatry in Kurdistan

Sir: I read Dr Berney's article (*Psychiatric Bulletin*, February 1994, **18**, 104–105) with great disappointment. I would remind him that Kurdistan is the northern part of Iraq with a history dating back 5000 years. Therefore I don't understand what he means by the 'Iraqi Invasion' in 1987.

There are 30 million Kurds living in Turkey, Syria and Iran and only a fraction of that number live in northern Iraq. If Dr Berney is really sympathetic to the Kurdish cause he should ask for the independence of the entire nation of Kurdistan and not just that part of Iraq!

Finally, I think Dr Berney agrees with other observers that Iraq's international integrity must be respected.

M. SHABAN, *Hartwood Hospital, Shotts, Lanarkshire*

Sir: I am sorry Dr Shaban was disappointed by my description of a visit which was focused on the furtherance of an aid programme. I included superficial comment on the politics and history as far as I felt it necessary to make sense of the account: brought up in Zimbabwe I recognise that this may sound naive.

I accept that Kurdistan is an ambiguous term. Although the Treaty of Sèvres (1920) provided for a wider Kurdistan, it was never ratified and the Treaty of Lausanne (1923) left the Kurds geographically fragmented. The present term refers to the Kurdish Autonomous Region which was established in 1974 with a separate Executive Council; an autonomy which appears to have become confirmed in the aftermath of the Gulf War. I find 'invasion', the term used within the country, quite appropriate for events which had such genocidal fury as to require United Nations intervention with the creation of the safe havens and no-fly zone.

I would agree that tampering with boundaries is complex and dangerous: Iraq's survival of the Gulf War is a witness to that. I cannot be drawn into a discussion of the policies of Turkey and Iran on whose goodwill depends the survival of the programme.

T.P. BERNEY, *Prudhoe Hospital, Prudhoe, Northumberland NE42 5NT*

Multidisciplinary teams in child and adolescent psychiatry

Sir: In the article by David Cottrell (*Psychiatric Bulletin*, 1993, **17**, 733–735) he refers to my own views on the subject (*Psychiatric Bulletin*, 1992, **16**, 33). He challenges the concept of all referrals being made to the consultant as unworkable as the consultant would need to assess all the cases. In my paper I indicated that the consultant would decide to whom the referrals would be delegated, after discussion at the team meeting. This process provides the best service for the patients and links the clinician on the team most suited for the needs of the patient. This I feel is the essence of multidisciplinary work.

I am aware that psychologists and others on the team receive referrals directly but these will not be brought to the team unless requested by the clinicians. This would clarify the boundaries between cases referred to the team and those referred to individual clinicians on the team.

Cottrell mentions the need for doctors to take charge, but it is not that doctors need to take charge, rather that, if leadership of multidisciplinary teams are not clear, patients are disadvantaged because of lack of clarity as to who is responsible. Therefore I proposed that, in a hospital setting, the consultant should be team leader, such clarity enabling the team the freedom of function to its optimum.

Working in the Mental Health Service of the Royal Children's Hospital, Melbourne for the past year, I had to apply for the team leader's post which was open to all disciplines. Currently

out of the four out-patient teams only one is led by a non psychiatrist despite the added incentive of extra remuneration.

I would therefore conclude that it is not that doctors would like to take charge but that if we don't who will?

JOHN MATHAI, *Royal Children's Hospital, Melbourne, Victoria 3052, Australia*

Sir: I read with interest the article by Cottrell (*Psychiatric Bulletin*, 1993, 17, 733-735) on multidisciplinary teams in child and adolescent psychiatry. Child psychiatry is in a peculiar situation as team members take similar patients without much inter-disciplinary differentiation in their work-load. Whether a team member is a medically qualified practitioner, nurse, psychologist, or social worker, children who are depressed, miserable, anxious, phobic, enuretic, or have a conduct disorder or some other diagnosis are taken, and managed. Moreover, most teams seem to have developed an aversion to pharmacological treatment, and therefore do not see the need for the consultant to be kept aware of all patients under his or her care.

If all members of a multidisciplinary team can screen and carry out therapeutic work of a diverse nature, it is likely that soon the realisation will dawn on general managers that the expensive consultant psychiatrists who provide no special input can be dispensed from the multidisciplinary team and concentrated at the tertiary care level to handle the minute percentage of cases that the multidisciplinary team cannot (Arya, 1993).

The justification of consultant psychiatrist as team leader is now 'required' and is an issue of discussion in a multidisciplinary team. It may have nothing to do with the leadership qualities, medical responsibilities, salary or managerial expertise of the consultant but rather that, in child psychiatry now, other team members provide equivalent expertise. No doubt many psychiatrists are beginning to see "the possible benefits of preparing themselves for diffusing authority in order to facilitate a model of care which best meets the needs of our patients" (Cottrell, 1993). Surely, in a multidisciplinary team, a democratic leader can only have claim over leadership if he or she has the advantage of specific expertise.

ARYA, D.K. (1993) Child psychiatric services: in crisis? *British Journal of Hospital Medicine*, 49, 699.

DINESH K. ARYA, *Peter Hodgkinson Centre, County Hospital, Lincoln LN2 5QY*

Sir: I suspect that the differences between Dr Mathai and I concerning the functioning of multidisciplinary teams are not great but nevertheless significant. Where we both agree is that

teams must have leaders to function efficiently. I also agree that this leader will often be the doctor. However, I do not believe that the doctor should have this role as of right in out-patient teams. I note with interest that Dr Mathai is team leader in his own team, but only after having to apply for the post. I believe that doctors often make excellent team leaders, but that they are better able to fulfil this function, and in particular gain the support of the team, when that team has had a say in the leadership role, rather than when they feel that a leader has been imposed on them.

It follows from this that I would disagree with Dr Mathai's suggestion that the consultant decides to whom referrals should be delegated, after team discussion. I would argue that the team should make this decision after discussion which would, of course, allow the doctor an opportunity for his or her say.

Dr Arya is concerned that consultants may be withdrawn from multidisciplinary teams and held in reserve for dealing with that "minute percentage of cases that the multidisciplinary team cannot handle". This is to misunderstand the model of teamwork that I am proposing. The strength of the multidisciplinary team lies in the team's ability to bring the expertise of all team members to bear on any one referral and to support whichever team member is seeing that case. While it is important to recognise those areas of commonality in the skills of team members, it is equally important to recognise, and respect, those areas of difference which exist. The contribution of a medically trained psychiatrist is, like the contributions of other team members, essential to the effective functioning of the team. Without it the "minute percentage" of cases that the team could not handle would inevitably grow, as it would if any of the core disciplines were absent.

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Diagnosis of personality disorder

Sir: Like Dr Steadman (*Psychiatric Bulletin*, 1993, 17, 774), I have found the diagnosis of personality disorder to be used less frequently in recent years; however, I am not sorry to see its decline. In my experience the term is often inappropriate and rarely qualified by subtype or justified by evidence. It thus becomes a diagnostic label which rather than enabling appropriate treatment, actively discourages therapeutic intervention.