

***Organization of mental illness services:  
The need for action research***

DEAR SIR

The July *Bulletin* seems to have been composed round the theme of organization. D. H. Dick (pp. 119–21) provided an excellent and graphic account of some of the problems currently bedevilling management of mental illness services, but failed to explain that little is known about organizing professionals, and that any development has the quality of innovation with all the associated practical and political difficulties.

The next article, by M. Frost and A. Liddell (pp. 121–22), quietly emphasized that psychologists would have to be organized into any comprehensive service. This increases organizational complexity, but seems inevitable given the current trend towards specialization. M. Best (pp. 124–25) offered similar visions from within the profession by suggesting major alteration in psychiatric training, but unfortunately did not spell out the implications for service provision. This seemed to confirm the argument put forward by P. Hill and H. Waters (p. 123) that psychiatrists, especially trainees and junior consultants, show a profound ignorance of, and therefore lack of responsibility for, the profession as a whole and the administrative and planning process within the NHS. Parliament, at least, seems concerned with services and their organization (pp. 125–26). The College also persists in its pursuit of patient protection through a legislated organizational form (pp. 130–32). Dr Freeman's review of 'Maybury' considers public relations (p. 133), and a letter from Dr Verma (p. 134) asks the question from which organizational solutions must spring: what is the work to be done?

There is undoubtedly an awareness (or at least an awareness of a lack of awareness) about the importance of organization. This encourages me to inform readers very briefly of the work of the Health Services Organization Research Unit at Brunel University. This Unit (HSORU) was set up initially in 1967 by the DHSS and operates by responding to requests for assistance with organization from individuals or groups within the NHS. We have worked a little in the mental illness field in the past<sup>1,2</sup>, but the research method is such that we cannot proceed without an increased determination by the profession to get a grip on its own organizational problems.

As Sir Desmond Pond suggests (p. 118), the re-organization of the NHS provides opportunities for change which may not recur for some time. At present, HSORU has several active projects, including one with a focus on psychiatric services. Our research unit offers the possibility of a systematic collaborative attack on the problems, and we would be interested to hear from anyone who wishes to pursue this path. Our immediate aim is to deal with current issues so as to bring about planned and evaluated change; the long-term research task is the development and testing of concepts and models which might be more widely applicable.

If sufficient interest is about, research conferences can be organized at Brunel University as well.

Psychiatrists already working in well-organized comprehensive services may wish to collaborate with the Unit in a more complex project we are planning. This aims to assist with problems of intersectoral integration: linking psychiatric and other health services, social services, educational services, penal and probation services, employment services, voluntary agencies and private practice.

WARREN KINSTON, MRCPsych

Brunel University,  
Middlesex UB8 3PH

REFERENCES

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- <sup>2</sup>— & HEY, A. (1978) *Organisation of Services for the Mentally Ill*. BLOSS Working Paper, Brunel University.

***Is dying the province of the psychiatrist?***

DEAR SIR

Dr Verma (*Bulletin*, July 1981, p. 134) questions the necessity of a psychiatrist providing support for a research team investigating psychological aspects of the management of terminally ill patients. He also asks whether dying is the province of the psychiatrist at all. These issues are closely related and I would like to deal with them together.

I do not think dying is particularly the province of psychiatrists, but it is a stressful life event and, as such, may precipitate vulnerable people into psychiatric illness. In my experience (over five years, with about two hundred dying patients) most people do have adequate resources to cope with dying. The conditions under which they are most likely to become overwhelmed and break down are:

1. Undue vulnerability to separation and loss, because these experiences have not been successfully worked through in the past;
2. Lack of support from at least one loved and familiar person;
3. Being made aware of their condition at a rate which is inappropriate for them, so that the natural processes of assimilation and adjustment cannot take place.

It is at point number three that the proposed research project could cause undue distress.

In most research interviews the patient knows more than the interviewer and he can choose how much he discloses. He may give away more than he realizes, through non-verbal cues, but at least he feels he controls the amount and rate of disclosure. The dying patient is in an unusual position in that the interviewer may know more about his condition than he does; or at least more than the patient is prepared to admit to himself or others. This means that the questions the interviewer asks or avoids, and his non-verbal cues, may inadvertently warn the patient about the seriousness of his situation before he is prepared to face it.