



columns

seeking funds remains a challenging and time-consuming activity. Henceforth, wherever we can secure adequate funding, it will be possible to initiate or continue with these projects after the campaign itself has ended. They, along with the website, will be adopted by the College's Department of External Affairs and, hopefully, provide increasingly firm foundations for the College in this clinical and political arena.

Our tendency is to stigmatise, whenever we experience fear, communication and empathy difficulties and related unpredictability in others. It is too ingrained to be kept readily in check. The tasks of alerting, informing and empowering us all will, therefore, continue. Have we made any impact so far? The campaign has been welcomed by many people and organisations. It has not been the only campaign. For instance, the Department of Health is currently

mounting a short-term, but very well-organised, campaign addressing employers, young people and the media. The World Psychiatric Association has a global campaign that specifically addresses the stigmatisation of people with schizophrenia. The World Health Organization (WHO) is taking the matter seriously. At a recent WHO meeting in Europe, we were gratified to be told that our campaign was the most comprehensive one on this continent at this present time. If it really is that good, we hope that others will speedily emulate those aspects that are good and build upon them. We hope to survey again, late in 2003 or early in 2004, the opinions of the general population. Providing we can get £30 000 worth of funding, we shall be asking the Office of National Statistics to use the same methodology and the same instruments as before to maximise the opportunities for comparisons. Whatever the

findings, they may defy explanation and attribution! But before then I hope that we shall have another opportunity to bring you up to date again with the campaign's activities during its concluding year. Meanwhile, please do use the toolkit, and especially the posters and advertisement whenever you can.

Professor A. H. Crisp Chairman; Changing Minds Campaign.

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obituaries

Russell William Andrew Charles Barton



Formerly Physician Superintendent, Severalls Hospital, Colchester, Essex, and later, inter alia, Director, Rochester Psychiatric Center (USA)

Russell Barton, the maverick Anglo-American psychiatrist who thrived on controversy, died after prolonged cardiac invalidity in June 2002, aged 78.

Barton was endowed with high intelligence and a comparable degree of personal courage. The former is exemplified by his clutch of academic medical qualifications gained in the UK and the USA; the latter by the courage he showed when, as a medical student, regardless of his health and safety, he volunteered to help the surviving skeletal, disease-ridden victims of Belsen, one of the most notorious purpose-built Nazi death camps, when it was liberated at the end of the Second World War.

However, sadly perhaps, at times Barton could exhibit a variety of courage

neighbouring on foolhardiness: he insisted on speaking his mind when others would have found it politic to keep their own counsel. A case in point was his allegation on 1 March 1963 at the annual conference of the National Association for Mental Health in London that 'dud consultant psychiatrists – it is not a few' should be given a golden handshake 'for a cheque for perhaps £5000 or £10 000'. It was a similar blunt allegation in a letter published in *The Lancet*, which he refused to retract, that led to him relinquishing his job. Shortly after this, he shook the dust of England from his feet to find his fame and fortune in the New World; a successful move, as his subsequent career was to prove.

Barton qualified MB BS(Lond) from Westminster Hospital in 1949. He completed his National Service in the Royal Navy after which he was appointed Registrar and Clinical Tutor in both medicine and psychiatry at Westminster. Having chosen psychiatry as his life's work, he began his training at the Maudsley under Professor Sir Aubrey Lewis. Then he was appointed Senior Medical Officer at Shenley Hospital, Radlett, Hertfordshire, to be followed by his appointment in 1960 to the important post as Physician Superintendent of Severalls Hospital, Colchester, Essex. He obtained the DPM(Eng) in 1954 and was elected to the foundation fellowship of the Royal College of Psychiatrists in 1971. To his great credit, he obtained the MRCP(Lond) in 1959, 10 years after he qualified.

Importantly, it was his experience at Shenley and Severalls, neither of which could be considered to be in the van of progressive thought and practice at that time, that led to the publication of

Barton's magnum opus, *Institutional Neurosis*. Published in 1976, it ran to three editions and was translated into several languages, including Greek.

In essence, Barton's thesis was that patients incarcerated in mental hospitals without employment or stimulation developed a neurotic condition over and above the psychiatric condition which occasioned their admission. In everyday parlance, he sought to demonstrate the age-old maxim, namely, 'No work is a dangerous occupation', a maxim as true for the insane as it is for the sane.

It is a fact that while Barton was at the helm at Severalls, the discharges plummeted. But – and here's the rub – was the dramatic fall due to an active pursuance of Barton's personal policy, or was it, as is claimed, an expression of genuine therapeutic miracles? The motion was actively, even acrimoniously, debated in the 1963 columns of *The Lancet*. The arguments for and against make intriguing reading and are strongly recommended.

What is beyond doubt, however, is that Barton's views were sweet music to the ears of politicians of both major parties and must have provided ammunition for those who advocated closure of the mental hospitals in favour of 'community care'.

The wisdom of the decision is still being debated and one wonders, if it ever came to a vote, how Barton would cast his in the light of today's experience, both here and in the USA.

Russell Barton leaves a widow, two daughters and many friends on both sides of the Atlantic.

Henry Rollin



columns

Russell Barton was a leading figure in the unlocking of wards in mental hospitals, in rehabilitation, and the move to community care in the middle of the last century.

As a medical student, Russell courageously worked in the recently liberated, infamous K.Z. Lager at Belsen. He qualified at Westminster Hospital in 1947. After National Service in the Royal Navy, he became a Registrar and Clinical Tutor (medical and psychiatric) at his old hospital. He then moved to the Maudsley Hospital under the formidable Sir Aubrey Lewis.

As a Senior Hospital Medical Officer at Shenley Hospital he led and inspired us to encourage patients with chronic schizophrenia to occupy themselves in small groups. He succeeded in unlocking wards, so transforming a situation in which half the 2000 in-patients in the hospital had been treated in three blocks of locked wards.

In 1960, he was appointed Physician Superintendent of Severalls Hospital, Colchester. He collaborated with Mapperley and Netherne Hospitals in a study, the results of which were published by Professors J. K. Wing and G. W. Brown in 1970. During the 8 years of the study, one-third of the long-term patients with schizophrenia improved clinically. The industrial work introduced at Severalls accounted for much of the clinical improvement there.

In 1971, he was offered financial incentives to relinquish his post and remain as one of the four consultants at the hospital: a firm believer in proper clinical leadership, he declined and moved to Rochester (NY) where he became Director of the State Hospital and Clinical Professor of Psychiatry at New York School of Psychiatry. He published *A Short Practice of Clinical Psychiatry* in 1975. In

due course, he retired from Rochester Psychiatric Center but continued to undertake medico-legal work. It is interesting to quote a press cutting in 1989 which recorded him as saying in Court, 'Translated literally, Mr Cleary, "distinguished colleague" means "bloody fool"'.

A certain extraverted flamboyance led some to underestimate him. Many of his aphorisms would put life into this account. On one occasion he said to me 'Not having been at the Maudsley, you will not have heard of Occam's razor'. I quoted the fourteenth-century original, at which his scorn deepened; 'At the Maudsley, it would have been regarded as a ridiculous affectation to quote it in Latin'.

Russell was a good friend and colleague and will be much missed.

Lindsay Hurst

reviews

Putting Assertive Outreach into Practice. A Development Tool for Team Leaders and Project Managers

By D Davidson and J Lowe
Brighton: Pavilion Publishing. 2001.
42 pp. ISBN: 1841960721

Leonard Stein, one of the original proponents of assertive outreach, was keen to reduce the 'pathological dependency' he felt was implicit in the individual keyworker model. Thus developed the 'whole team approach'; all the members of a team work with all the patients and share clinical responsibility. This aims to reduce both keyworker stress and the 'dependency' of the patients.

This pack, for developing assertive outreach teams, emphasises the importance of such an approach. However, many authorities in the area do not buy into this model. They argue that the road to independence is via a period of dependence and that forming individual relationships is important. On a practical level, trying to routinely rotate visits between all team members is inefficient and labour intensive. Engagement, so crucial to successful assertive outreach, can also become more difficult.

That there is any debate about this issue would be a surprise to those using this pack in isolation, as it sticks very much to the mantra that the whole team approach is the crux of successful assertive outreach. It is aimed at leaders of developing teams, and concentrates on

putting issues into practice. It consists of a training pack accompanied by a video. Also included are some clear, simple handouts covering the background and core components. The emphasis is on practical issues such as the daily hand-over, and training sessions are suggested.

The video presents footage of two teams, both in the voluntary sector, with no medical involvement. The 'whole team approach' is explained and the video demonstrates the degree of communication necessary to enforce this rigorously. Team members discuss the model from their perspective and you get a feel for their enthusiasm and dedication. However, the lack of medical input is reflected in the case histories; in one, a patient is left in his room not eating or drinking for 4 days and not having seen a doctor, while the team try to engage him and his family.

This pack may be of interest to developing assertive outreach teams, but will only be relevant to those who have already made an informed decision to adopt the whole team approach. The emphasis on teams in the voluntary sector does not reflect the self-contained teams with active medical membership suggested by the government's Policy Implementation Guidelines. Assertive outreach needs to be flexible, and many teams have found in practice that, rather than sticking rigidly to the ideology of the whole team approach, a mixture of both models has evolved.

Aileen O'Brien Lecturer in Community Psychiatry and Specialist Registrar to the Wandsworth, Assertive Community Treatment Team, St George's Hospital Medical School

A Suitable Space. Improving counselling services for Asian people

By Gina Netto and others
Bristol: Policy Press/The Joseph Rowntree Foundation. 2001.
34 pp. £10.95 (pb).

This is a well-written account of a qualitative investigation into counselling services and their suitability for Asian people. Interviews were held with 38 Asian men and women to explore their perceptions and views about counselling, examine their experiences of accessing and using counselling services, explore their preferences for all types of service, and examine the cultural sensitivity of counselling provision.

Although respondents often put forward family and friends as confidants, it was clear that at times of distress they valued an independent source of support, and professional help, in particular. Understandably, those who had experienced counselling were greatly in favour of it and those with no such experience knew little of the services. Coping mechanisms included maintaining a semblance of normality and continuing as if nothing untoward had happened. This may explain non-presentation of distress to health and counselling services. Those with experiences of counselling had found it useful and were able to articulate the relief they experienced both metaphorically and in concrete terms, sometimes very shortly after beginning counselling. Interestingly, this relief was partially manifest as better sleep, less panic, less chest pain or fewer coughing fits. These