Colleges are not advisable but I would encourage all members to communicate their concern, at both local and national levels, to as many people as possible.

J. L. T. BIRLEY
President

A unit for the 'intractably disturbed'

DEAR SIRS

Oxford has for over 25 years been engaged in the active rehabilitation of the chronically mentally ill. For the last ten years we have increasingly concentrated on that group which is usually called the 'new long stay'. We have avoided that term and developed services such as the Young Adult Unit (Pullen, 1987; 1988) which aim to prevent patients becoming long stay. In general the extensive network of specialist units, group homes and hostels has allowed us to prevent the build up again of large numbers of long stay patients. Nevertheless, in recent years it has become apparent that there are a few patients whom we feel it will never be possible to manage safely outside of a hospital setting.

This group includes men and women whose psychotic illness is so severe and so refractory that they would either be at risk to themselves in the community or would be a danger to the public. We exclude those who can be deemed a "grave and immediate threat to the public" because by definition such patients should be treated in a Special Hospital. It follows that our group needs to be contained but does not need the most sophisticated levels of security such as found in Secure Units.

It is difficult to predict how many such patients will be generated in the future, but our experience in Oxford suggests that for us it is at least one per million population per annum. We have, therefore, decided to open a unit specifically for this group of patients.

It is clear that such a unit must somehow balance the need to be a safe and containing environment with the necessity of providing a place which can be home for a patient, perhaps for 40 years. I would be grateful if anyone who is planning, or better still has built, such a unit, would get in touch with me in order to share information.

G. P. PULLEN

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Reference

PULLEN, G. P. (1987, 1988) The Oxford Service for the Young Adult Chronically Mentally Ill. *Bulletin of the Royal College of Psychiatrists*, **11**, 377–379; **12**, 64.

Beware of your friendly social worker

DEAR SIRS

Perhaps the most satisfactory way of resolving the disturbing problems raised by Dr Bridges (*Psychiatric Bulletin*, April 1989, **13**, 197–198) is to involve patients more actively in decisions about confidentiality. Individuals using psychiatric services – whether as in-patients or out-patients – are doing so to obtain *medical* assessment and treatment, and therefore the ethics of medical confidentiality apply. This is clearly recognised in DHSS guidelines.

Multidisciplinary working has developed without the express consent of patients. In addition there is no generally agreed style of multidisciplinary involvement, excepting perhaps between the medical and nursing professions and certain technical services. Where detailed discussion of sensitive and personal matters may occur – for example, in ward rounds, in the presence of professionals *not directly* working with the particular patient – our own ethical guidelines surely demand that the patient should know that this may happen and have a right to restrict discussion of their affairs, while under medical care, at least in accordance with the statements of the General Medical Council quoted by Dr Bridges.

Consultants may well have differing views on the extent to which restricted discussion will impair the ultimate treatment – based on their perceptions of multidisciplinary practice and the relative weights that they may attribute to perspectives unique to separate disciplines, improved information, or general experience that may be brought to ward meeting – but in most cases it must surely be the patient's decision to determine, in consultation with the psychiatrist, how their treatment is conducted. In the same way 'joint' interviews should not be forced on patients unless there are particular reasons why the presence of a third party is desirable.

Finally would it be mischievous to speculate on whether the unit manager or social workers referred to by Dr Bridges would express similar views if in receipt of services for themselves or involved in administration in the private sector?

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Assessment of forensic cases on remand

DEAR SIRS

There is a serious problem in relationship to making psychiatric assessments of patients on remand in prison. I usually find that there is a complete absence of the depositions related to the offence for which the prisoner has been remanded. As a result, it is not always possible to make a satisfactory assessment

when being asked to consider taking a patient under Section 37 of the Mental Health Act.

To give two brief examples, one of a relatively minor nature: a man with a past history some years ago of aggressive hypomanic states requiring inpatient treatment, had on this occasion, been aggressive to his wife as she would not give him the keys of the car. He had already lost his licence for driving under the influence of drink. When seen his mental state was quite settled. However, it would have been desirable to have had access to his wife's statement to the police at the time of the offence to get a clear picture of his mental state at the time.

In a more serious case, there was a prisoner who had assaulted another man with an axe at a party, claiming he had been provoked with a row over a girlfriend. There was also a question as to how much he had had to drink at the time. Since the incident he had developed a reactive paranoid psychotic state. To make a meaningful evaluation it would seem vital to have access to the eyewitness's account of his state at the time.

If asked by a solicitor to prepare a report for their client, one would be given access to all the relevant depositions. However, when routinely seeing patients on remand at the request of the Prison Medical Officer these documents are not usually available.

I feel that the Royal College of Psychiatrists should pursue this matter by insisting that the Prison Medical Officers and the requested visiting psychiatrists are provided with the full background details of any offence. I feel sure that members of the College placed in similar circumstances would agree with this view.

R. Lucas

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Psychiatric day hospitals

Dear Sirs

The psychiatric day hospitals have been providing a service for over 40 years. It has been said that the only thing that day hospitals have in common is that they are entirely different (DHSS, 1969).

There are conflicting reports on how effective day care can be and for what type of patient, and there have been few conclusive findings showing any specific factors that would lead to a better service for patients attending day hospitals. It is accepted that it is best to separate psychogeriatric patients from younger patients and to separate the neurotic population from the psychotic and long-term younger population (Farid, 1988; *Lancet*, 1987).

A practical issue that has not been discussed is the administrative responsibility for day hospitals. Some day hospitals are led by a nominated consultant psychiatrist who takes responsibility for all patients attending the hospital. Other colleagues refer patients to him and he usually assumes full responsibility until their discharge from the day hospital. In practice, what usually happens is that the consultant in charge uses most of the facilities for his own patients and other consultants are usually reluctant to refer their patients for someone else to assume responsibility and prescribe treatment for them.

The other extreme is for all consultants to provide and prescribe treatment for their clients attending day hospitals resulting in confusion of the existing day hospital staff as to who is actually in charge and how to reconcile the different models of treatment and different clients attending for the same treatment facility at the same time.

I wonder whether anyone has looked at how important different models of leadership can be in effecting success, or lack of it, in day hospitals, or whether people have thought of a practical and innovative solution for this problem.

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The election of College representatives

Dear Sirs

Another wadge of ballot papers for College posts has recently tumbled through my letter box. I am dismayed to see that the accompanying biographical notes are, as usual, uniformly dull. Moreover, they do not help me distinguish which candidate would be most suited to the job. All are eminent men who have served on numerous committees and have large numbers of publications to their names. Given the very similar descriptions of all the candidates, how am I, as an ordinary member of the College, going to choose the best man, or woman, for the job? As it stands, my choice is determined by such chance factors as sex (I vote for any woman on principle), having read an interesting paper by them or having heard a complimentary rumour about them on the grapevine.

Surely this is no basis for making important decisions about College representatives? Could we not hear from these people why they believe they should get the job, what particular talents they would bring to it and what they intend to do if elected?

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