Support and stay

DEAR SIRS

Dr Macdonald is quite right that there are "marked differences in the balance between health and social services provision for the elderly demented across the country" (*Psychiatric Bulletin*, April 1991, **15**, 224). The environment in his district sounds very different to that in our own.

The question remains about the difference between a psychogeriatric service and a social service. It is our opinion that caring for most dementia sufferers requires special skills. Given that much care will be provided by staff who do not have the benefit of a lengthy professional training, it seems to make sense to employ these people as part of a NHS psychogeriatric service. Within this service it is possible to arrange some basic training from doctors, nurses, OTs, physios, psychologists and even social workers. Furthermore, it enables the nursing assistants to have quick and easy access to the pool of expertise about dementia from these professionals.

We also do aim to offer our services to *all* clients with dementia.

None of this is to say that we do not work closely with social services, nor that we may not change in the future.

PAUL WHITBY
JOAN RULE
GILL JOOMRATY

Tonna Hospital
Tonna, Neath
West Glamorgan SA11 3LX

Confidentiality and psychiatric practice

DEAR SIRS

J. V. McHale raises important forensic issues in her note (*Psychiatric Bulletin*, March 1991, **15**, 60) Recent legal decisions in the North Americas could well soon find their way to these shores. In those parts, it has been decided, in Tarasoff and other cases that mental health professionals can be held liable for failing to warn third parties of possible dangers to themselves (Mackay, 1990).

In a comparable field of activity, probation and parole officers in the USA have, in some instances, been held to be similarly so liable (though there have been conflicting judgments) (Sluder & Del Carmen, 1990). It is to be hoped that those in the indemnity business are busy exploring the implications of Egdell and the North American cases. Forewarned may well prove to be forearmed.

HERSCHEL PRINS

Midlands Centre for Criminology and Criminal Justice
Loughborough University
Loughborough LE11 3TU

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Carpets for patients and staff

DEAR SIRS

Dr Jolley (*Psychiatric Bulletin*, March 1991, **15**, 168) obviously does not know what he is missing and it is not the smell!

Contrary to his philosophy, I determined that the new unit for my services which has both assessment wards and continuing care wards should be carpeted throughout.

Yes, I mean throughout patient and staff areas excluding only bathrooms and lavatories. Our patients have complete freedom of movement and are not required to wear catheters. They are regularly taken to the lavatory by nursing staff and it is the high quality of nursing care which underpins the success we have in keeping our patients continent and our carpets odour-free.

The addition of carpets to an environment, already considered quite homely by virtue of other furnishings, completes the picture by changing the 'feel' and greatly reducing the rather bright, noisy quality so typical of many other uncarpeted institutions. The excellent domestic service does indeed play a vital role in maintaining the carpets in their present condition but I can assure Dr Jolley that this is not at the expense of the secretarial delays described by him.

Dr Jolley has visited a number of units which he feels support his anti-carpet philosophy. I urge him to widen his horizons, remove his noseplug and make haste to my service to be enlightened.

STEPHEN EDWARDS

Edward Street Hospital
West Bromwich
West Midlands B70 8NJ

MCQs in the MRCPsych

DEAR SIRS

The recent publication of four articles on MCQs in the MRCPsych (*Psychiatric Bulletin*, February 1991, **15**, 87, 88, 90 and 108) is to be applauded for providing some helpful guidelines on how to approach them and should be welcomed by trainees as the uncertainty of what awaits and is expected of them is a source of considerable anxiety. Such strategies as those suggested may help reduce the anxieties induced by this particular part of the exam and improve candidates' performance. The fact that candidates are obliged to pass the clinical examination and