should be spent in the psychiatry of old age. The 1987 Handbook uses instead the phrase "a recommended period of four years and a minimum of three" as a criterion for appointment to a consultant post for all branches of psychiatry other than in the psychiatry of old age, general psychiatry with a special interest, and in the special hospitals. In the psychiatry of old age the element of psychogeriatric experience is now to be "usually eighteen months."

I understand that this is not just a paper change, for I believe that the College has instructed its representatives on Advisory Appointments Committees to adhere to these guidelines rigorously. That the College is doing so may be because of its wish to be consistent with its arguments to the Joint Planning Advisory Committee on senior registrar numbers, which resulted in an increase in manpower approval. However, it will be some little time before these new senior registrar posts have any influence on the number of applicants for consultancies. Therefore, by diminishing the supply of suitable applicants, through applying these new criteria before these new senior registrar postholders have completed their four years of training, the College is inducing a dearth of "suitably qualified applicants" for consultant posts throughout the country.

A further interesting aspect of this situation is how little this change has been discussed outside of Belgrave Square. Indeed, many of my colleagues would seem to have been unaware that the JCHPT had made such a change. I would be interested to hear through your correspondence columns whether this experience is widespread, and what are the views of your readers on the appropriateness of the College moving the goal-posts in this way.

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Higher media profile for the College

Dear Sirs

I am writing as a consultant psychiatrist who is a current BMA Divisional Secretary (West Glamorgan) and who was also a member of this College's first Collegiate Trainees' Committee.

In the course of my work with the BMA I have become conscious of the admirable efficacy of the Association in day to day political matters due in no small part to the efforts of Mrs Pamela Taylor and her highly professional staff in the BMA Public Affairs Division. Thanks to this unit the BMA is able to plan its responses in the media to current issues, especially perhaps Government policy, and to deliver a polished performance which helps the Association maintain its key role in influencing public opinion on health matters.

While recognising the differences between the functions of a Royal College and a professional association which is also a trade union, I have been concerned that there have perhaps been times when our College does not seem to have reached this standard of media professionalism and rapidity of response. The public image of psychiatry is currently less satisfactory than many of us would wish and I am sure that many are also conscious that some of the voluntary bodies and pressure groups have at times been more effective in influencing mass public opinion than our own profession. Examples of this include some of the consequences of the 1983 Mental Health Act and also the worrying backlash against all biological treatments following the, quite proper, concern over benzodiazepine prescribing.

Currently of course medical services in this country, including our own speciality, are faced with a most serious threat in the form of the Government's White Paper – *Working for Patients* – which seems to put in jeopardy the very continued existence of the NHS in its present form. I am sure the Presidents of the Royal Colleges did not realise what they were unleashing when they petitioned Downing Street! We need to consider carefully the implications for psychiatry. Will we be the "left overs" after the more prestigious specialities have "opted out", and how will the essential integration of hospital and community services fare under such a novel structure? In the absence of any pilot studies no-one knows but we need to be vigilant. I spoke briefly to some of these issues at the recent BMA Secretaries' conference where we were also addressed by Sir Roy Griffiths who, however, seemed to be strangely silent concerning his report on community care!

These are matters which will need intensive debate and political lobbying over the forthcoming months and I wonder if the College needs to adopt a somewhat higher media profile to try to cope with them. Clearly these are issues where professional opinion and general political views are frequently intertwined and public statements, therefore, require careful consideration. However, it is necessary for our profession to grasp these unpleasant nettles if we are to continue to command public respect.

Philip Marshall

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I appreciate Dr Marshall's remarks. The College's first task is to communicate as best as it can with all its members. That is why I have written to all members on two occasions about the White Paper and about the College's views.

I have been impressed, and so have the Government, by the unified response of the whole medical profession to *Working for Patients*. This has been carefully organised. Press conferences by individual

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

Young Adult Unit
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Littlemore, Oxford OX4 4XN

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