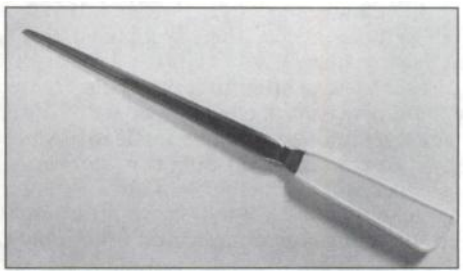

Drug company gifts – beware!

Sir: Recently I completed a survey of potential weapons to be found in interview rooms at our hospital, which revealed many objects, e.g. scissors, which had been left in these rooms without any realisation of their potential as weapons. I was surprised therefore to see one of our local drug company representatives carrying a large handful of what at first glance appeared to be stiletto knives into the unit, which were subsequently distributed among the clinicians' offices. I later found out that they are intended to be used as letter openers. These items are 9 inches long and have a 6 inch thin pointed steel blade and a 3 inch white plastic handle with the drug company's product name on it. If used as a weapon this could easily produce a fatal injury as it is an ideal design for producing a deep stab wound. I suggest that these gifts should either be disposed of safely or confined to a locked drawer. With the recent tragic death of a mental health care worker in Torbay, units should ensure that potential weapons such as these are not allowed in mental health units.

ALAN LILYWHITE, *Barrow Hospital, Bristol BS19 3SG*

Need for off-licence owners to issue guidelines of good practice

Sir: We are a central London out-patient alcohol team. In February last year one of our clients was found dead after a relapse. We were told that the local off-licence delivered to his doorstep as he had restricted mobility due to peripheral neuropathy. A number of similar incidents have since been reported to us, not all fatal.

We know that the larger supermarket chains are promoting home deliveries free if over a certain quantity is ordered. Some of our clients have used this service while relapsing and report more difficulties in terminating their drinking.

There are two main issues to be considered: first, the quantity of alcohol delivered on a daily basis and second, how long this delivery should continue when it is clear that it is having such a detrimental effect on the health of the individual.

We believe off-licences have some responsibility for monitoring their home delivery service and raising awareness about problem drinking among employees. We wonder whether it is time for the ethical issues to be raised by the Royal Colleges and BMA to influence off-licence owners to issue guidelines of good practice to avoid fatalities.

ATHANASSIOS DOUZENIS, FRANCIS KEANEY, CLAUDIA SALAZAR, ANDREA MILBRANT, SUE FAWCETT, and KATRIN EDELMAN, *Riverside Alcohol Service, 5 Wolverton Gardens, London W6 7DY*

False teeth and Alzheimer's disease

Sir: We were hurt by Levinson's assertion (*Psychiatric Bulletin*, 1993, **17**, 504) that our study of false teeth in AD should be construed as a hoax (defined in Chambers 20th Century Dictionary as a 'deceptive trick'). Our data were real and not fictitious. It was our interpretation of them and the style in which the paper was written which has led to comment. It was also serendipitous that the paper appeared in the April edition of the *Bulletin*.

The data came from a large survey which has been published extensively in a number of journals and also in summary form (Burns & Levy, 1992 – Clinical Diversity in Late-Onset Alzheimer's Disease, Maudsley Monograph, No. 34, Oxford University Press). One part of the salami which we decided to slice and present in light-hearted form were our observations of false teeth. This has led to wide publicity in the scientific and lay press and we were flattered by Dr Levinson's additional interest in our work. Mercury in dental amalgam is obviously an important source of this neurotoxin and it is intriguing that we may have come upon something, without a predetermined specific hypothesis, which is something not altogether unusual in our approach to research!

We are delighted that Dr Levinson has brought this to our attention. Our earlier conclusion that research into AD might be directed towards the mouth, may indeed be a prophetic statement. To turn out to be prophets would surely be a legacy any clinical researcher would be proud of.

ALISTAIR BURNS, ROBERT HOWARD, RAYMOND LEVY, and HANS FÖRSTL, *University of Manchester, School of Psychiatry and Behavioural Sciences, Withington Hospital, West Didsbury, Manchester M20 8LR*

Compulsory admission to hospital

Sir: Sammut & Sergeant present an interesting analysis of disagreements between psychiatrists and social workers over compulsory admission to hospital. (*Psychiatric Bulletin*, **17** 1993, 462–465). However, I think they need to be cautious in

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their analysis and resist the temptation of saying 'doctor knows best'.

First, were the index assessments made at the same time? Mental distress fluctuates and therefore one assessment may not concur with another. Second, the findings that 24 of the 33 cases subsequently received in-patient care informally suggests that many of the recommendations were at least partly unnecessary because informal admission subsequently followed.

Third, the emergence of dangerous behaviour in the undetained group seemed little different to the detained group, suggesting that hospital detention may not be the most effective way to treat the disturbed behaviour.

Clearly statements like an individual "lacks insight" and that "electro-convulsive therapy is not necessary" make a nonsense of the purpose of mental health legislation but whether these sorts of disagreements should be aired so publicly seems questionable.

We have recently started to undertake multidisciplinary (clinical) audit to look at untoward incidents, and at meetings such as these the various ideological differences can be addressed. A paper of this sort could, I am sure, be presented by social workers to illustrate how autocratic psychiatrists are and that we need more liberal mental health legislation with clients having more say. Mental Health Act assessments need to be handled carefully and a decision reached only after considered discussion with all interested parties.

A. N. WEAR, *Royal South Hants Hospital, Southampton SO9 4PE*

Medical care of the long-term mentally ill in hostels

Sir: Dr Essex's review (*Psychiatric Bulletin*, 1992, **16**, 126) concerning different patterns of care for long-term psychiatric patients living in hostels (Horder, 1990) needs re-addressing. One hostel, where a GP shared the care with a psychiatrist, is a model fraught with potential problems. Both professionals visit the hostel which encourages continuing institutionalisation, the residents continue to receive care passively and the potential for duplication of work exists. At another hostel, the psychiatrist dealt with all the problems which smacks of a need to over-control ex-hospital patients or an inability to let go. Who is dependent on whom? Why were the residents registered with a GP? This is poor use of a psychiatrist's time. A third hostel had the residents consulting GPs as ordinary NHS patients, and consulting a psychiatrist when necessary (similar to long-stay rehabilitation hostels in Gloucester). This model has not led to problems in communication or defining medical responsibility in Gloucester (cf. Horder, 1990) and hostel staff can access the psychiatrist and help patients see their GP.

Dr Essex's suggestion that only GPs are necessary, and will not have to deal with unusual problems, cannot be true. He misleads by saying the hostels contained chronic schizophrenic patients. Over one third of patients have a different psychiatric diagnosis. Some have multiple diagnoses encompassing organic and functional psychiatry as well as physical morbidity. Hence the need for shared care. Many also have severe communication and behavioural problems.

Dr Essex wonders whether GPs should be given extra remuneration for the responsibility of these hostel patients. Using the third hostel model negates any justification for this – local GPs do not complain of extra workload and some feel it is reduced.

Dr Essex has not mentioned that Dr Horder's study found "the GPs in the enquiry were unanimous in saying that the work had not been unduly difficult or arduous, and that off-duty work was minimal". Several made spontaneous comments about its interest and value.

The debate about medical and psychiatric care and responsibility for the long-term mentally ill in the community continues. Further informative studies like Dr Horder's should be welcomed as the move out of the asylums will necessitate caring for more ex-hospital patients in these settings.

HORDER, E. (1990) *Medical Care in Three Psychiatric Hostels, Hampstead and District Health Authority*. Hampstead and South Barnet GP Forum and Hampstead Department of Community Medicine.

JES ROBERTS, *Coney Hill Hospital, Coney Hill, Gloucester GL4 7QJ*

The mental health needs of refugee children

Sir: The Department of Health's Health Care (Medical) Division has been in negotiation with the Refugee Council over the possibility of forming a list of those mental health professionals who have an interest in, or are engaged in, work with refugee children in Britain.

I would like to hear from any psychiatrists, even if we have had previous contact, who would be willing to have their names put on such a list, with a contact address and telephone number and the nationality(ies) of the children they could help. This list would be held by Ms Ros Finlay of the Refugee Council and will include clinical psychologists and child psychotherapists as well.

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