In my reply of 22 January 1990, I informed you that I would raise this matter with the Justices' Clerks' Society (JCS), with a view to securing an improvement to the current system. I did so, and the JCS considered alternative ways of taking the matter forward.

I recently learned that Mr Heath, the Honorary Secretary of the JCS, arranged for the following entry to be inserted into the December 1990 issue of the Society's bulletin:

'Council has received complaints from the prison medical authorities that in many cases where defendants are remanded in custody for the preparation of psychiatric reports, the remanding court fails to forward a statement of the reasons why the court has sought such a report. This failure to complete the statement required by section 30 of the Magistrates Courts Act 1980, and rule 24 of the Magistrates' Courts' Rules 1981, deprives the medical staff of essential background information and may contribute to delays in reports being prepared. An example of the statement which should accompany all requests for psychiatric reports is to be found on page 7272 of the current (i.e. 1990) edition of Stone's Justices' Manual.'

I enclose a copy of the entry in the current edition of Stone. I am very sorry that this matter has taken some time to resolve."

The relevant enclosed entry from Stone's manual was as follows

"(a) On exercising the power conferred by section 30 of the Magistrates' Courts Act 1980 by remanding the accused in custody, the court is required, by Rule 24 of the Magistrates' Courts Rules 1981, in Part 1: Magistrates' Courts; Procedure, ante, to send to the institution to which he is committed a statement of the reasons why the court is of opinion that an inquiry ought to be made into his physical or mental condition and of any information before the court about his physical or mental condition. Home Office Circulars Nos 113/1973 and 1/1975 recommend that the following form should be used for this purpose –

Remands in custody under Magistrates' Courts Act 1980, as 10(3) and 30.

Statement of reasons for medical enquiry (Rule 24)

Name of defendant .....

Court..... Date .....

Offence.....

Section under which remand is ordered .....

.....

Dear Sir,

This defendant has been remanded for a medical report. To assist the Medical Officer I give below the information available.

1. Type of report (e.g. on physical or mental condition or suitability for particular treatment).
2. Reasons which led the Court to request the report.
3. Previous medical history of offender and family history, so far as known.*
4. Particulars of circumstances of offence (including, if the offender is of no fixed abode, the place where it was committed, is known).
5. Previous conduct, including previous convictions if known*
6. Address and home circumstances of offender*
7. Name and station of police officer concerned with case
8. Name and telephone number of any probation officer appointed to or having knowledge of the case.

It would be helpful to the court if your report could indicate –

a. whether the defendant suffers from any form of mental disorder, if so:
b. whether he is in need of or capable of gaining benefit from treatment, if so –
c. where and by whom this treatment can be given,
d. whether it should be as an in-patient or out-patient and
e. prognosis where possible.

Yours faithfully,

The Governor,
HM Prison

*Where the required information can best be conveyed by attaching a copy of a report or statement in the court's possession, all that need be entered here is "See attached ...".

It is therefore clear that the Clerk to the Justices Court has a statutory duty to supply the Governor of the Prison with a full background report. Each time we visit a prisoner to prepare a psychiatric report and the background information is lacking, we should notify the Prison Governor to remedy the defect. Only by persistently drawing attention to the lapse, can we hope to facilitate an improvement.

I also would suggest that the College send a formal letter to all Prison Governors reminding them of the need to ensure that Section 30 of the Magistrates Courts rule 1981 is carried out in practice.

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Observation areas: an alternative to seclusion

DEAR SIRS

All psychiatrists are familiar with the problems presented by managing the severely disturbed patient. Beside the danger the patient may present to himself or others; there is the additional problem of the disruption such a patient can effect upon the ward as a whole. Traditionally, the psychiatrist has two possible remedies; the use of heavy sedation and/or the placement of the patient in seclusion. The use of seclusion is a controversial practice and may be subject to excessive use.

On a recent visit to Stockton Hall Hospital, York, I noted the creation of an 'observation area', as an alternative to seclusion. The 'observation area', comprised several spacious rooms, furnished, with access to television etc., where a disturbed patient could be supervised by several nursing staff, in isolation from

other patients. When not in use the observation area is locked off and not staffed.

The creation of such 'observation areas' is dependent on the institution having adequate space to put aside a lounge area for only intermittent use. This capability may be lacking in facilities where space is at a premium. The concept is, however, worth exploring further, as any mechanism which lessens the need for seclusion is highly desirable.

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Diogenes syndrome

DEAR SIRS

The description given by Drs Anderson and Bach-Norz (*Psychiatric Bulletin*, 1991, **15**, 574) of an elderly woman living in extreme squalor, hoarding objects for no useful purpose and refusing all offers of help sounds like that of the Diogenes syndrome.

An individual showing the syndrome is typically untidy, unsavoury and often insanitary and psychiatrists may be asked by social workers, housing departments, general practitioners and/or neighbours to take away such a blot on the landscape.

My own belief is that psychiatrists should treat the sick and not act as agents of social control. If this lady presents a danger to the public health or to the safety of buildings then these dangers can be readily dealt with by well established procedures without any need to invoke the Mental Health Act perhaps inappropriately. It may be that her house has not been made safe because the relevant authorities do not want her to return to it and much prefer to have her out of sight.

On an entirely separate point, may I ask what is the difference between deceit and deception. My dictionary gives "deceit – act of deceiving" and "deception – act of deceiving".

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Psychiatry in war

DEAR SIRS

I was pleased to learn that my former colleague, Dr Gamble, returned safely from his exploits in the Gulf (*Psychiatric Bulletin*, 1991, **15**, 505). He trusts that the NHS will "have little to do in the wake of this war". Those of us serving with the Forces at the time of the Falklands war remember similar sentiments being expressed then about the apparent lack of psychiatric casualties, but we now know that the hidden morbidity was substantial (James & Lovett, 1987).

Since leaving the Army, I have come across many anecdotal case reports from civilian colleagues treating Falklands veterans suffering from psychological problems consequent upon that war. I have also personally seen many veterans from past wars who never came to formal psychiatric attention at the time but suffered nevertheless, helped where possible by the Ex-Services Mental Welfare Society. I would think it unlikely that the Gulf War will be different in this respect. Many soldiers will have been involved in burying large numbers of Iraqi dead, and this places them at risk in a similar way to those of the rescue services who dealt with the dead from the Zeebrugge, Lockerbie and Kings Cross disasters.

The Gulf war has already had an impact on my work. Several patients, veterans of past conflicts, reported an increase in intrusive memories and flashback phenomena when the Gulf war was at its height, provoked by the vivid television images from the desert. I suspect that my experience here is by no means unique. I would be surprised if in time, further work more directly related to the Gulf conflict does not come the way of NHS practitioners.

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Reference

JONES, G. & LOVETT, J. (1987) Delayed psychiatric sequelae among Falklands war veterans. *Journal of the Royal College of General Practitioners*, **37**, 34–35.

A list of experts who can give advice to individuals suffering from post-traumatic stress disorder resulting from situations such as the Gulf War is available from Vanessa Cameron at the College.

Services the consultant in mental handicap provides

DEAR SIRS

In recent years the demedicalisation of mental handicap has raised the questions of what the consultant in mental handicap does and where there is a need for such posts. From the points of view of practical work, audit and business planning, it is useful to record what tasks and services can be performed or provided only by the consultant. The following pilot list shows that there is still a range of activities that only the consultant can do.

Psychiatric history taking, examination, assessment, diagnosis, treatment, prognosis, of outpatients referred by general practitioners, other consultants and community services; responsibility for overall treatment of in-patients under the consultant's care and co-ordination of their rehabilitation, resettlement and discharge; provision of psychiatric notes, reports, letters, including reports