visits that can be made within a certain time period in a particular specialty; therefore, if patients go elsewhere for their treatment or have continuing unmet health needs, there is no way of quantifying (and therefore costing) this. Secondly, the open access of patients to specialist services tends to exaggerate any excess costs that are incurred. In this country, general practitioners act as a gateway to specialist care, limit its inappropriate use and, it is hoped, deal with minor psychiatric morbidity in a more cost-effective way.

More than ever before we are being asked to prioritise and choose between competing health care needs. It is therefore important to be able to justify the allocation of resources to treatment modalities that are expensive in their use of professional time for illnesses that generally speaking are in the mild-moderate range of severity. Notwithstanding this, non-psychotic mental illness produces its own economic burden on the community (Wilkinson, 1989).

If its treatment is cost-effective as well as clinically effective, there is a case for expanding resource allocation to psychotherapy services. Only further controlled cost-benefit studies of specific psychotherapeutic treatments can solve the problem satisfactorily.

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References

EARLL, L. & KINCEY, J. (1982) Clinical psychology in general practice: A controlled trial evaluation. *Journal of the Royal College of General Practitioners*, **34**, 377–380.

GINSBERG, G., MARKS, I. & WATERS, H. (1984) Cost-benefit analysis of a controlled trial of nurse therapy for neuroses in primary care. *Psychological Medicine*, **14**, 683–690.

WILKINSON, G. (1989) Estimated costs of neurotic disorder in UK general practice 1985. *Psychological Medicine*, **19**, 549–558.

A full list of references is available from Dr Mallett.

A very dangerous practice

DEAR SIRS

Every psychiatrist who has assessed mentally abnormal offenders remanded in prison will be aware of one glaring fact: that absolutely no information is available about the offence.

In fact, the Courts do not pass on any information even to the Prison Medical Officers. All that they have, and all that the psychiatrist has access to, is the offender's own account of the offence.

What tends to happen is that the offender, his mental illness notwithstanding – or because of the mental disorder – gives a watered down account of the offence, and claims that he is not in touch with any relatives. It is only after his admission to an open ward for assessment for reports that the true extent of his dangerousness became evident – when relatives telephone the ward to explain that the offender had tried to kill someone who lives down the road from the hospital, and that the threat was still being made.

On two occasions, though it must have been obvious from my report that the offender lied to the psychiatrist, the Courts went ahead and made an order to remand the offender to hospital for reports or treatment, and even completed a Hospital Order. My attempts to obtain an explanation from the Courts of their refusal to give some information to the Prison Medical Service about the offences committed by the inmates have been unsuccessful.

I would like to suggest that the College, especially its Forensic Psychiatry Specialist Section, look into this matter, and perhaps try to reach a compromise position with the Courts, to ensure that the assessing psychiatrist is made aware of the offence prior to the assessment in prison; failing which an incorrectly informed psychiatric report – one whose content reveals a serious disparity between the offender's account of his offence and what the Court knows – should not be a basis for a disposal to hospital.

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DEAR SIRS

Dr Azuonye has criticised the unwillingness of Courts to share information with psychiatrists considering patients for admission, or with prison medical officers. Sir Donald Acheson, the Chief Medical Officer, made some of his considerable reputation through his Oxford Record Linkage Study, in which he showed the gains to patients from linking up the many scattered records about them. However, in the case of remand prisoners, it is important that such linkage does not prejudice their chance of a fair trial, and for instance a magistrate who considers a defendant's suitability for bail, and so studies his previous criminal record, is automatically barred from trying the case. This may explain why Courts sometimes seem reluctant to release information, although bureaucratic inertia may not help.

There is usually little problem in obtaining background information in serious Crown Court cases. If the Court requests a report, copies of the depositions (the prosecution evidence in the case) are often supplied automatically, or can be obtained on request, particularly with the reminder that the Lord Chief Justice ruled some years ago that psychiatrists preparing court reports were entitled to see the

depositions. If the report is requested by the defence, the solicitor will usually provide what is needed, although a few lawyers who rarely undertake criminal work may need gentle education about psychiatrists' needs. In Magistrates Court cases the situation is more difficult, as there are no depositions. Nonetheless it is usually possible, by polite persistence, to obtain useful information from the arresting police officer, the liaison probation officer, the defence solicitor, or the Crown Prosecution Service.

The recent experience of two of our Manchester forensic senior registrars, conducting a pilot study for a court duty psychiatrist diversion scheme, showed that being physically present in the Court complex was the ideal way both to obtain information and to arrange transfer of mentally abnormal offenders to psychiatric care. Joseph and James and Hamilton have made similar findings in two London Courts.

In conclusion, Dr Azuonye has a case but it is considerably overstated, despite some continuing difficulties in communication between the Courts and assessing psychiatrists. Representatives of the College are about to have what is likely to be the first of a series of meetings with the Law Society and the Bar Council about matters of joint interest, and I will take up this point with them, as well as drawing it to the attention of the joint Home Office and Department of Health Review on Mentally Disordered Offenders (Reed Committee).

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Action on anomalous aspects of the Mental Health Act 1983

DEAR SIRS

Since the Mental Health Act 1983 came into force, there has been a steady stream of papers, articles and letters pointing out aspects that are illogical, ambiguous, impossible of application, or inadequate in their provisions such as approval of doctors under Section 12(2) of the Act; unhappiness with the Draft Code of Practice; the provisions regarding appeals against detention under Section 37; application of Section 2; and the responsibilities and authority of Approved Social Workers. But despite the volume of persistent correspondence about the anomalies of the Act and the Code of Practice, nothing has changed.

If there is a department of the College that looks into issues surrounding the Mental Health Act, what is it doing by way of response to our observations? If there is not, we must surely create one, to liaise between us and those who make the laws of the land, so as to draw their attention to the amendments that we would like to see made.

There has been some correspondence regarding whether forensic psychiatry is all we need to address the legal aspects of psychiatry, or whether a separate department is required. My answer is that forensic psychiatry is – or ought to be – about the intervention of psychiatrists in the management of mentally abnormal offenders. Forensic psychiatry should not be attempting to be the sole source of expert opinion on the legal aspects of psychiatry. Besides, since the mentally abnormal offenders constitute a small proportion of the mentally disordered, it is clear that forensic psychiatry could not address all of our questions about the provisions and application of the entire Mental Health Act.

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DEAR SIRS

Dr Azuonye is under the doubly mistaken impression that forensic psychiatrists wish to be the sole source of expert opinion on the legal aspects of psychiatry, such as Section 12 approval and the Code of Practice (no longer "Draft") and that the College has no influence on such matters. Most of these are vital to general psychiatrists, and are dealt with by the new General Psychiatry Section, by the Public Policy Committee or by E & F (Executive and Finance), and come before Council. The College was effective in transforming the original Draft Code of Practice into something much more appropriate and makes useful recommendations about many other legal issues.

Forensic psychiatrists work with legal requirements most of the time, and should acquire extensive knowledge and experience of them. So legal issues are usually presented to the Forensic Section Executive for comment, as well as to other College committees, but the Section does not make College policy or claim the right to speak for the College as a whole.

We have an unusually democratic and representative Royal College, and as a former Division Chairman I advise Dr Azuonye to take up his concerns through his College Division or by joining appropriate Sections and Groups of the College. I see no need at present for a separate legal aspects of psychiatry department.

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