services, under the chairmanship of Dr John Reed, published its final summary after a gestation period of exactly two years. A total of 276 recommendations were made but only one forms the basis of this review, namely that regional health authorities should regularly assess the needs of their residents for secure and non-secure hospital provision. In view of the proposed increase in spending on medium secure developments from £3 million in 1991/2 to £18 million in 1992/3, the assessment was limited to secure hospital provision.

The two papers by O'Grady *et al*, consist of such an assessment in Leeds. The first paper looks at the relative contributions of three tiers of secure hospital provision to the city's population, namely the local special care unit (SCU), the regional secure unit (RSU) and special hospitals (SH). Interestingly, there is no reference to the private sector which makes a substantial contribution to secure hospital provision in some parts of the country. Over a six month period all the patients admitted to the three levels of security were monitored. The SCU had by far the most admissions, 64 compared with five to the RSU and one to SH. Most of the SCU patients were referred from general psychiatric wards and the community, including police referrals, and only a minority were offender patients. None of the five RSU admissions came from the courts or prison, in contrast to the majority of admissions to the RSU from other parts of the northern region. There was little movement of patients between the SCU and RSU. The authors conclude that local units are required to meet the total need for secure hospital provision which cannot be met by the RSU alone. Implicit in their account is the view that the SCU is taking patients who should have gone to the RSU, particularly prison referrals.

The second paper attempts to assess the degree of unmet need for secure hospital beds in Leeds. Relevant statutory and voluntary staff working both in hospital and in the community, particularly among the homeless, were asked to identify individuals who might require secure hospital treatment but who had not received it, or for those already in hospital, whether they were appropriately placed. In addition all remands to prison for psychiatric reports over a six month period were monitored. Thus unmet need fell into two broad categories, those in the community or prison trying to get into a secure bed and those in secure provision who might be in the wrong tier. In the latter group the numbers were small; three psychotic patients with learning difficulties in SH should ideally have been transferred to a lower level of security; six cases were stuck in the RSU and SCU but they had accumulated over a five year period. Similarly of the 23 prison remands, two required and received admission to a secure bed and no absolute unmet need was identified.

The community survey revealed a very different picture. Sixty-nine cases were identified by their carers as requiring secure hospital provision although the researchers discounted 20 cases. Of the remaining 49 individuals, their unmet needs broadly consisted either of difficulty in access to statutory agencies, or a lack of stable, structured residential accommodation. The group as a whole tended to be disruptive, potentially violent recidivists living an itinerant lifestyle, often referred to as "rejecting and rejected".

Taken together these two papers show that surveys of unmet need will give very different results depending on where you look. In Leeds, there appears to be good liaison between prison and secure hospital and most patients are in the correct tier of hospital security. A need is identified for long term medium secure beds for a small number of patients, principally those with learning disabilities who have accumulated in the system. In the community, on the other hand, there is substantial unmet need for local secure hospital provision. Although the local SCU takes the vast majority of referrals to secure beds, it is this facility which is failing to meet the needs of the community and perhaps this is where the money should be spent.

The way forward would be for the SCU to shed its RSU-type role regarding offender patients and concentrate on responding rapidly to community referrals, particularly those which come through the police and the new court liaison schemes. It is notable that of the 49 individuals in the community who might require secure hospital admission, none had in fact been referred, perhaps a reflection of the carer's pessimism about the likely response. Currently, community workers soldier on until a crisis develops, often in the form of a criminal offence, and there is little statutory management which could be considered proactive. As the authors point out, there needs to be considerable inter-agency cooperation to meet the needs of this group, without which any hospital response will continue to be reactive and crisis-led.

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Indian Journal of Social Psychiatry (Commemorative Issue WASP 92). Editor: P. Kulhara. Vol. 8 (3/4)

In a country the size of India, where caste, creed and class are important features for daily functioning, other social factors also play a significant role in the pathogenesis and prognosis of mental illness. Various international studies have established that

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the prognosis of certain mental disorders, e.g. schizophrenia, is better in developing countries. It is vital to identify factors that make it so, and the changing role of family, urbanisation and rapid Westernisation, especially with economic liberalisation and the influence of satellite television, cannot be underestimated. As the editor of the Journal under review asks in his editorial, "Are some of our problems like increased social unrest, waves of agitations and protests, the menace of drug abuse and the arrival of the dreaded evil of AIDS due to rapid social change? Could it be that technological growth has not only provided prosperity to a few but the parallel boom in telecommunications and information technology has brought into sharper focus the economic disparity and the gulf between the rich and the poor?". These are relevant questions from the perspectives of the psychiatrist, not only in India but also in developed and other developing countries. The answers to these questions hold the key to improved health – mental and physical – to fit in with the Alma Ata declaration. The Indian Association for Social Psychiatry started producing its own journal in 1985. The current quarterly production indicates the growing importance of the subject.

The issue under review is a double issue commemorating the 13th World Congress of Social Psychiatry held in new Delhi in November 1992. It contains three invited articles: first one on parasuicide and suicide by Professor Venkoba Rao; one on behaviour and health in relation to HIV by Drs John and Jayaraj; and one on social disadvantage, by the current president of the Indian Association for Social Psychiatry, Professor Varma. Underlying themes of these three papers offer theoretically relevant ideas for practice of preventive psychiatry. The role of society in determining the help-seeking behaviour dependent upon attitudes to mental illness as well as service provision is vital in containing and managing mental distress. This is where these papers come into their own. Seven original papers deal with various topics ranging from the role of life events and relapse in alcohol dependence, through insight in psychosis to clinical depression in children. These papers are followed by an article on 'The caricature of the Indian psychiatrist: a study in psycho-satire'. In addition to one case report, there are three brief communications. The journal provides an interesting snap-shot view of Indian psychiatry in an Indian context. Whether this will lead to a moving image, time will tell.

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Let's Go Wheelies! Ill conceived behaviours amongst staff caring for people with dementia. By Brian Lodge. A BASE Publication, 119 Hassell Street, Newcastle, Staffordshire ST5 1AX. 1992. Pp 69. £4.00.

In this booklet, Brian Lodge has put together a series of telling snapshots of what life can be like in a place for the victims of dementia.

In the Foreword, Tom Arie says this is a booklet for everyone involved in trying to help and support people with dementia. He goes on to say that his fantasy is that some rich person would pay for the book to be produced on such a scale that free copies came through the letter-box of every home. I certainly think everyone involved with old people, be they demented or not, should have a copy and read it regularly.

All of us in the field have seen and heard the behaviours described in this booklet and it is so easy for us to do some, if not most, of the wrong things mentioned. The table of contents is a teaching experience in itself, with such titles as "Sit down John, please – Now!", "Please lock the door!" "Come over here, Mary!", "What can you expect at her age?", "Sans teeth? Sans dentures? Sans ...?" "She's confused! She needs something!", "Needs writing up for something!", "All they need is to be kept clean, fed and watered!", "Come on George! Strip off! You're going to bed!"

This is a delightfully well-written booklet with many lessons for all of us. I highly recommend it and share Tom's fantasy of a rich person making sure that we all get a copy free, while compensating Brian Lodge and the publishers handsomely for their excellent job.

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