In my view, the CPA should apply to all people in contact with mental health services, whether mentally ill or not. An advantage of this approach is that it avoids philosophical problems about the nature of mental illness! I am not saying it does not make sense to concentrate on those with longer term, more severe disabilities and particularly those known to have a potential for dangerous or risk-taking behaviour. But current guidance does not explain how to concentrate on this group. True, those most at risk will be on the supervision register, but the category of those who present special risks is wider. The CPA applies to all mentally ill people and should be applied if relevant to other mentally disordered people.

Nor is there complete guidance about what should be recorded under the CPA. When are formal review meetings necessary and how valuable are they? Would it not be better to introduce a system of community ward rounds?

These clinical issues have become entangled with the political. Mental health services should resist this intrusion and develop systems that provide good care in the community.

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Community psychiatry: under-remuneration for challenging outreach work

Sir: Community psychiatry is not a job for those who expect their work to be orderly and to present to them at their desk. It is important to be able to respond to need in the community in a varied and innovative way. Sometimes this is time-consuming and extremely challenging. In the 'new NHS' it is of concern that this work may go financially unrewarded.

Case example. Section on the number 12 omnibus. When patients are ill they do not always report to hospital or sit at home. Many leave home and roam the streets by day and night. Following extensive efforts to contact a very ill patient both in the High Street and at home (five visits in total) it was decided to convene two doctors and a social worker outside 'Macdonalds' in an attempt to engage the patient. Relatives, and even shoppers in the street, had by now voiced their grave concern at the health of the patient. The police had felt unable to act on their own by using a section 136 of the Mental Health Act. With a bed organised, police and ambulance requested and everybody assembled we waited, and we waited. At a second attempt the patient again failed to arrive. A few days later a relative phoned to say that the patient was very disturbed and in the High Street. Racing to the scene on a number 12 bus (parking takes forever in Camberwell) it was clear that old type London buses which have no doors are a great asset to community psychiatrists as you can hop off as soon as you see your patient. The patient was seen outside 'Curry's' and was very disturbed. The police were called on the mobile phone from the porch of 'Dixons' opposite and the patient was at last brought to hospital under section 136, and then placed on section 3.

A brand-new mobile phone backed up by a good old London bus and huge effort was followed by excellent response to treatment and the patient thanked us for our efforts. I am delighted to say that the patient remains well, compliant with treatment and is now better than for several years.

The effort and innovation needed to enable this person to receive treatment was enormous. There were eight community visits by between one and three professionals at any one time. This entailed somewhere between 15 and 30 hours of clinical time. The monitoring of clinical activity by our local health authority is based on face to face contacts with patients. Vast efforts resulted in a single effective meeting by one clinician with a patient. The standard charge for such a contact is £70. Nothing else could be charged for according to our present arrangements. Our efforts were thus effectively financial suicide for the service.

I report this case not for its uniqueness or unusual clinical significance but because it is an example of the importance of ensuring that contracts between providers and purchasers reflect good psychiatric practice. I believe that as services become increasingly driven by cost considerations there is a risk that the most difficult outreach work may be financially unrewarded and therefore neglected by services that are stretched both financially and in terms in manpower. I hope that contracts and clinical activity monitoring systems will continue to allow occasional substantial outreach work.

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Making community care work

Sir: I am a parent whose mentally disordered son died partly because of a lack of community care. Grieving parents and loved ones need to know that lessons from the past are learnt, so that future tragedies might be best avoided. This I have found frustrating. I would like to share with your readers some ideas about future research.

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Sometimes mentally disordered people are refused admission to a psychiatric unit or abruptly discharged because of a violent act or the suggestion of a history of violence. This certainly seemed to happen in the case of Christopher Clunis; the more disturbed he became the less effective his care became. Surely there should be research about how many patients are refused admission or abruptly discharged and what subsequently happens to them.

There seem to be problems about confidentiality when carers contact psychiatric services with their concerns over patients who are becoming violent or aggressive. There is a need for guidelines about how such calls from carers are handled by psychiatric units and those guidelines should be subject to clinical audit. Sometimes it seems that concerned carers are simply ignored and no action seems to be taken.

There seems to be hardly any research about the safety of carers. Life-threatening assault may be rare but frightening assaults and aggressive behaviour are very common. It can disrupt family life, leading to young family members staying away because of safety fears and chronic disruption of carers' sleep.

There seems to be a real problem with police liaison and patients sometimes fall between the police and the psychiatric services, neither willing to step in. There need to be guidelines about what information is passed onto the police.

I hope your readers find these thoughts of some help as they continue to try and make community care work; if it is to work carers need to be listened to.

MICHELLE TWIGG, *16 Frobisher Green, Torquay TQ2 6JH*

Protecting vulnerable elderly people from risk

Sir: Morris & Anderson's description and discussion of the use of the Mental Health Act in the elderly is a welcome presentation of the relevance of this provision in good psychiatric care in old age (*Psychiatric Bulletin*, August 1994, **18**, 459–461).

We would strongly endorse their view of the value of detaining patients with severe dementia who are at significant risk. We pursue an active policy of intervention when the community mental health team, in conjunction with the family, other caring agencies and the primary health care team, believe that the risks have become too great for an individual to remain at home in reasonable safety. The care programme approach has been helpful in formalising the process of consultation and decision making (Broughton & Divall, 1994). The majority of patients brought into hospital in this way rapidly settle, cease to express the desire to return home, and can often be discharged to appropriate residential or nursing home accommodation.

We concur with their view that use of the Mental Health Act makes explicit the lack of competence on the part of the patient to make decisions about their care, and by so doing, gives them and their relatives proper legal safeguards.

We have argued similarly that guardianship is also an important power, allowing clarity about decision making for the incompetent dementing elderly, where total co-operation may be absent, usually through lack of insight and determinedly independent pre-morbid character. In the Bath Health District area of Avon County (approximate population over 65 of 22,000), we have been instituting about ten new guardianship applications per year for the last three years. In research, which is currently submitted for publication, we have demonstrated that the applications have achieved the aims they were intended to meet, and the use of guardianship has been well understood, and thought helpful by relatives of the patients and others concerned in their care.

We therefore believe that, even without amendment of the present legislation, guardianship does offer a way to protect vulnerable elderly people from risk, and safeguards their legal rights. We would encourage others to consider making more extensive use of this provision.

BROUGHTON, M. & DIVALL, P. (1994) The care programme approach: the experience in Bath. *Psychiatric Bulletin*, **18**, 77–79.

PAUL DIVALL, *Bath Mental Health Care Trust, St Martin's Hospital, Bath BA2 5RP;* and GERALD RYAN, *Avon Social Services, Lewis House, Manvers Street, Bath*

Informed consent?

Sir: A. White (*Psychiatric Bulletin*, August 1994, **18**, 507) questions the acceptability of oral consent for ECT obtained from a man whose delusional system prevented him from signing a form he believed Satan had signed. There is no legal requirement for informed consent to be recorded in writing; oral consent is as valid but may result in problems should a dispute arise needing evidence. Hence written consent is the norm for many procedures.

A signed consent form does not necessarily mean informed consent has been given and may therefore give a false sense of security. To be valid, the patient needs to have understood, in broad terms, the nature, purpose, principal benefits, unwanted effects and alternatives to