for Police, Probation Service, solicitors and courts; prescription of medicines; classification of patients, e.g. ICD; medical certification, eg, fitness for work, consent to treatment, death certification; provision of certificates for the Court of Protection, e.g. CP3; Responsible Medical Officer, 'RMO', duties and commitments; completion of documents under the provisions of the Mental Health Act by consultants approved under Section 12 of the Act; completion of reports for Mental Health Review Tribunals, including Second Opinion reports; provision of psychiatric evidence as professional witness in Court, including attendance at inquests; teaching generally on medical aspects of mental handicap; supervision and training of junior medical staff and senior registrars; psychiatric and medical research; provision of consultant cover for colleagues on leave or absent; participation in medical audit; psychiatric advice on service needs, development, planning and staffing for management; attendance at professional meetings and committees; and work in connection with professional organisations, e.g. The Royal College of Psychiatrists.

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Psychiatric referrals to emergency clinics

DEAR SIRS

Recent publications in the *Psychiatric Bulletin*, Gee (1991) and Haw *et al* (1987) have examined the issue of psychiatric referrals to emergency clinics. The proper assessment and management of crises and avoidance of hospitalisation when appropriate is important, especially in these days of increasingly limited NHS resources.

Our hospital recently carried out a survey of patients presenting on an urgent basis to the duty psychiatrist over two months in an effort to audit the use of this avenue of referral.

In total, 131 patients were seen as urgent referrals. We found that 70 (53%) of the patients seen had referred themselves v. 33 (25%) who were referred by their general practitioners. The remainder of patients had been referred by other agencies (police, social work department, Alcoholics Anonymous, etc).

Interestingly but not unexpectedly, we found that GP referrals were more likely to require urgent admission when compared to self-referrals: 24 of the 33 GP referred patients required admission (72%), v. 20 of the 70 self-referred patients (28%).

There were more self-referrals outside working hours: 46 of the 70 self-referrals (66%), and the admission rate for patients who self-referred rose as the day progressed. Of the 24 self-referrals seen from 0900–1700 hours, four required admission (16%). Eight of the 28 self-referrals seen from 1700–2400 hours required admission (28%). Six of the 18 self-referrals seen from 2400–0900 hours required admission (33%). Similar trends were not evident in the GP referred population.

These findings raise several interesting questions which require further investigation. Are patients good judges of their need for acute psychiatric help? Are patients more unwell at night, or does the duty psychiatrist's threshold for admission change as the day (and night) progresses? Is the level of training of the duty psychiatrist an important factor? Do patients abuse a psychiatric emergency service because it is so freely accessible? Is a 24-hour 'walk-in-as-you-please' service a luxury in our current NHS?

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References

GEE, M. (1991) Self referral admissions. *Psychiatric Bulletin*, **15**, 329–330.

HAW, C., LANCELY, C. & VICKERS, S. (1987) Patients at a psychiatric walk-in clinic – who, how, why and when. *Bulletin of the Royal College of Psychiatrists*, **11**, 329–332.

Patient involvement in their psychiatric care

DEAR SIRS

Dr Pilgrim (*Psychiatric Bulletin*, 1991, **15**, 370) should be reassured that considerable advances have been made with regard to patient involvement in their psychiatric care, and the issues he raises are already being seriously addressed by the profession.

We wish to make the following points in connection with the issue he raises.

(a) Consent to treatment is an issue which is afforded the highest importance in psychiatry, in which it is well recognised that mental illness raises particular problems in this respect. The Mental Health Act Commission has examined this issue and a Working Group of the College has reported on this subject in relation to patients with impaired volition.

(b) Physical treatments used in psychiatry do have powerful effects, both beneficial and adverse. We believe that any debate about the risks of treatment must also include examination of the extensive evidence as to the beneficial effects, as well as the risks of untreated serious mental illness.

(c) Dr Pilgrim may find ward rounds distressing and humiliating, but in a recent comprehensive survey of our long term in-patient population we found little evidence for this, and more than half (54%) of our patients stated that they wished to attend. We believe that this justified our established practice of inviting patients to attend on an individual basis, and that a blanket policy change away from patient attendance was not in keeping with our patients' wishes. We regularly seek the views of our patients in relation to all aspects of the service and adapt our practice accordingly, as well as having a lay advocacy system available to patients.

Incidentally, 84% of our patients felt that their treatment had been explained to them in a clear manner and 90% were satisfied with the way in which they were treated by staff.

We believe that our practices are relatively commonplace in British psychiatry and that there are currently many areas of concern with regard to the welfare and rights of the mentally ill to which Dr Pilgrim and colleagues could turn their attention.

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The standard Eire of the mean

DEAR SIRS

To call Ireland "Eire" is by now a sort of chronic standard error of the College exemplified by the new Membership List for 1991. A correction of at least two standard deviations is needed to approximate to minimum linguistic propriety in time for the next Annual Meeting in Dublin. The name of my country in the Irish language is indeed Eire. In the English language Eire translates to Ireland. To confuse the two languages is as ill informed as it is impolite. The insertion of Eire in an English text is equivalent to substituting Belge for Belgium, Danmark for Denmark, Espagna for Spain and so on – which our Editors would not dream of doing. Please note too, that Northern Ireland is a political, and southern Ireland a merely geographic, entity, indicating in latter case nothing more than the 50% of Ireland below its own waist. This is why we do not talk of Western Wales, Upper Gateshead or Middle Market Harborough. The purely defensive strategy of some Irish contributors to the Journal of insisting on the Republic of Ireland is not to be encouraged as it might justify the English psychiatrist who, on learning of my home address, sympathised with me on my having to come down to London on the overnight train for College meetings.

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P.S. For the title of this letter I am heavily indebted to our Immediate Past President.

Patterns of referrals

DEAR SIRS

It is possible to draw alternative conclusions from the study by Ridley and colleagues (*Psychiatric Bulletin*, August 1991, **15**, 471–472). They claim that the referring doctors were unaware that an intervention had been implemented. Yet referral rates changed significantly following intervention from 57 and 46 over eight months to 34 and 22 over a similar period. This represents a fall of 40% and 52% in referral rates in the two groups. Perhaps the intervention caused a change in the pattern of referrals.

The failure of "intervention" to alter attendance in the "ambulance group" may be explained if this group has a higher level of disability and therefore greater need; this is not clear from the paper.

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QALY delusions

DEAR SIRS

It has long been recognised that the content of delusions and hallucinations may change in response to cultural factors and personal experience. They have shifted from religious delusions to those involving space flight and inter-galactic warfare.

One of our patients recently claimed to hear voices saying, "She's taking up too much money, we'll have to get rid of her". Is the first case of the Government Health Service reforms being incorporated into a delusional system?

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