the columns

correspondence

Acute hospital care

Sir: We have read with interest the editorial by Dratcu (*Psychiatric Bulletin*, February 2002, **26**, 81–82). In developing countries such as ours mental health has come into national focus, with policy makers and health administrators recognising the importance of improving mental health services following the publication of the World Health Report (World Health Organization, 2001).

This document places much emphasis on care in the community and de-institutionalisation. In Sri Lanka an international conference on mental health and psychiatry, organised by 'Sahanaya' (National Council for Mental Health) in April 2002 addressed the issues and challenges in community mental health care. Many international participants with experience in community care, especially from the UK and USA, cautioned the proponents of community care from rushing into such a model with scarce resources. They raised the practical implications of closing down large mental hospitals overnight, such as homelessness, social deprivation and even patients ending up in prisons. They reiterated the importance of recognising the role of acute hospital care and ensuring adequate provision of hospital beds and services for those with mental illness.

In Sri Lanka, with a population of more than 18 million people, there are but less than 2000 beds for psychiatric patients, with more than 1500 beds being confined to two mental hospitals. This, by any standards, is far below expectation. Most patients in the developing world, however, are traditionally managed in the community by family and friends. It is the severely ill, who are not stable enough to live and survive in the community, that remain in the mental hospitals. Experience shows that the readmission of these patients on discharge is also high.

This is by no means an attempt to downplay the role of community care in the developing world. On the contrary, care in the community should be promoted, even championed, but not for the sake of aping models implemented in the developed world that may not be relevant to our setting. Community care will have to be seen in its context and developed accordingly. The hazards of discharging patients with mental illness without sufficient care facilities, such as increased rates of suicide, have been addressed before (Morgan, 1992). It would be pertinent to strike a balance between community care and de-institutionalisation so that individual patients and their carers are not sacrificed on the altar of ill-planned but well-meaning programmes.

MORGAN, H. G. (1992) Suicide prevention. Hazards on the fast lane to community care. *British Journal of Psychiatry*, **160**, 149–153.

WORLD HEALTH ORGANIZATION (2001). *Mental Health: New Understanding, New Hope*. World Health Report 1020–3311. Geneva: WHO.

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Police case disposal: an introduction for psychiatrists

Sir: Bayney and Ikkos (*Psychiatric Bulletin*, May 2002, **26**, 182–185) provide a helpful outline of the elements of the police decision-making process with respect to referrals of those with mental disorder. However, they make two important omissions. The first, and most significant, is the implication that the decision to prosecute is a police one. It should be emphasised that while the investigation of crime is undoubtedly a core police role, the decision to prosecute lies with the Crown Prosecution Service (CPS) and not with the police force. It is the role of the police to charge an individual if they feel it appropriate and to then refer the case to the CPS for consideration.

Second, the role of the CPS at the pre- and post-charge stages is not included. *The Code for Crown Prosecutors* (Crown Prosecution Service, 2000) notes that both before referring a case and during the prosecution, the police have a key liaison role. This role involves both discussing cases in which a decision to make a formal CPS referral has not yet been made, and in providing further information to the CPS as a prosecution proceeds. The police and the CPS, although independent of each other, are fundamentally linked, and the omission of the CPS impairs a full appreciation of the process under scrutiny.

CROWN PROSECUTION SERVICE (2000) *The Code for Crown Prosecutors*. London: Crown Prosecution Service.

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Clinically useful electronic patient record

Sir: We were delighted to see the report by Searle *et al* (*Psychiatric Bulletin*, April 2002, **26**, 145–148). We too have had tremendous success with an almost identical system developed in collaboration between the IT department and clinicians (Hunt, 2002). We now have discharge summaries, patient letters and Care Programme Approach reviews available networked across three London boroughs, and multiple sites. Like many others, we found that the patient-based IT systems on offer could not cope with storing and retrieving the complex clinical information that we all need when managing patients. However, using the network that was built to enable communication across the trust, we can now access detailed clinical information 24-hours a day when needed, and have gone a long way to ironing out the information problem caused by community teams being based away from in-patient units. The system has been quick and simple to implement and well-received by staff. The key difference with our project is that each patient has only one file, with multiple pages of separate letters within it. We suspect that this makes retrieval and searching somewhat easier. Interested people are welcome to contact us by e-mail in the first instance.

HUNT, J. (2002) The M: drive project. *British Journal of Healthcare Computing and Information Management*, **19**, 20–22.

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https://doi.org/10.1192/pb.26.8.315-b Published online by Cambridge University Press