at several major teaching hospitals. The Austin Hospital, which is part of the University of Melbourne, has for the past ten years had psychiatric registrars undertaking consultation liaison experience and they have all clearly met the criteria your committee has suggested.

A part-time Director of Consultation Liaison Psychiatry has been responsible for coordinating the service in conjunction with a number of consultation liaison psychiatrists who together with a registrar have dedicated units to look after. In this way the non-psychiatric medical staff know who they are to contact for help with patients.

The Victoria State Psychiatric Services also have two third year registrars who rotate through this service for six monthly periods as part of their five year training programme. The hospital has its own registrars who are attached on an annual basis and may be involved with consultation liaison work for three years, rotating into different areas as needs are met.

Commencing this year we have a full time Fellow in Consultation Liaison Psychiatry who has completed the (Royal Australian and New Zealand College of Psychiatrists) exams.

Austin Hospital is famous for its large spinal injuries unit which has been well described elsewhere (Judd *et al*, 1989). In addition, for the past five years we have been the liver transplant centre for Victoria which has involved a considerable amount of consultation liaison work. This hospital has also a very large neurological and neurosurgical unit and is a centre for the Australian temporal lobectomy programme for patients with intractable epilepsy and the usual large general medical and general surgical units. The registrars are also rostered to the Crisis Service where they take part in the assessment of people with deliberate self harm.

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Discharge delays

DEAR SIRS

We read with interest Eapen & Fagin's correspondence on discharge delays (*Psychiatric Bulletin*, February 1993, **17**, 121). We carried out a similar study. To identify those patients on acute wards with an admission duration longer than three months, establish the proportion in need of alternative facilities, the nature of these facilities, and to identify the lack of access to alternative facilities, we sent a questionnaire to the consultants in charge of the two admission wards and two early rehabilitation wards of Napsbury Hospital and Barnet Psychiatric Unit. Items in the questionnaire included the placement of first choice, whether alternative placement was agreed, and if so, why patients were not transferred. The project was repeated on three occasions: August 1991, January 1992 and June 1992.

In August 1991, 44 patients remained in hospital for longer than three months and were currently on acute and early rehabilitation wards; 17 (39%) were reported to be inappropriately placed. In January 1992 and June 1992, 21 (51%) out of 41, and 16 (34%) out of 46 patients spending longer in hospital than three months were placed inappropriately. During this period the number of overall admissions did not change. Although in June 1992 the total number of inappropriate patients remaining for long periods on the wards had decreased, the fall in number was too small to be thought significant from a clinical and managerial viewpoint. The main reasons for patients being inappropriately placed were unavailability of long-term places in Napsbury Hospital; delays in transfer to resettlement team/hostel placements; and delays in housing and funding by local authorities. The results indicated that action was necessary. Places needed to be made available for long-term patients in independent accommodation in the grounds of Napsbury Hospital, although this did not open until February 1992. This made no difference to patients remaining too long on the wards audited, as the total number of beds continued to decline because of financial pressures. It was considered appropriate to change an all-female ward into a mixed ward, thereby providing places for men with chronic mental illness who were otherwise occupying beds on acute and early rehabilitation wards. Financial pressures have not yet permitted this to happen.

Liaison with social services took place to ensure that patients discharged into the community received appropriate funding in respect of housing and resettlement in supervised accommodation. A recommendation was made that the applied ban on health authority top-up funding for placement of the mentally ill in community facilities should be lifted. As expected, financial limitations and lack of provisions in the community are the reasons for delays in discharge of most patients remaining longer than three months in hospital. These factors are crucial for the successful implementation of community care. All aspects of the Community Care Act should have been implemented by 1 April 1993 when local government was given control of its financial aspects.

The community care grant is considered by most local authorities to be inadequate. Although a specific grant for the mentally ill will be made available through the regional health authorities, early indications are that funding will be inadequate. As a result more acute beds will be taken up by chronically ill patients who would be better cared for in the community.

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The social state

DEAR SIRS

I thought Campbell and Szmukler's proposal for writing up the social state on every case very interesting (*Psychiatric Bulletin*, January 1993, **17**, 4–7). It would emphasise the importance of social factors in the aetiology and prolongation of illness and would be of practical help at care planning meetings with Social Services. I think, however, their list of points is incomplete as it does not give a heading for responsibilities. Some patients relapse, not because of lack of family or contacts, but because of the pressures put upon them by unavoidable responsibilities such as the care of children, elderly or disabled relatives, and I would suggest they expand their framework to take account of this.

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Who acts as the consultant's nominated deputy?

DEAR SIRS

The article Section 5(2) of the Mental Health Act 1983: Who acts as the consultant's nominated deputy? (*Psychiatric Bulletin*, 1992, **16**, 759–761) highlights problems and uncertainties most junior doctors will face. However, two issues should have been addressed in more detail.

(a) Transfers between hospital sites under Section 5(2) of the Mental Health Act was found to be a problem for example between a peripheral psychiatric unit. While the article was primarily an audit I do feel the opportunity should have been used to resolve the dilemma. As far as I am aware for transfer to another hospital a patient on Section 5(2) would have to be transferred to Section 2 or 3.

(b) Although not categorically stated the audit would seem limited to psychiatric wards. One area that has always created problems is the care of disturbed patients on non-psychiatric wards. It is quite clear from the Mental Health Act that the nominated deputy should be that of the patient's consultant, irrespective of what ward he or she is on. I find that junior doctors in other specialities are extremely hesitant in accepting this responsibility. Perhaps this issue needs to be raised more often in the induction meetings for junior doctors.

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Reply

DEAR SIRS

The comments made by Dr Kazeem are similar to those raised by Fuller (1993). The aim of our study was to explore the variation between health districts in the interpretation of who is most suitable to act as the RMO's nominated deputy. As part of the study, comments about difficulties encountered with the use of section 5 were also invited. A very small proportion of respondents had encountered problems with the transfer of patients between psychiatric hospital sites while detained under section 5. In each case the difficulty had been subsequently resolved. Clearly this is an important issue; however, it is not possible to make a blanket statement to cover all such cases. Inevitably, whether a problem is posed by the transfer (e.g. from a peripheral psychiatric unit to a psychiatric intensive care unit), is dependent upon the structure of local services. If both hospital sites are headed by the same management team as one unit, then the transfer would be within the regulations of the Mental Health Act (1983).

As described in our paper, the study was conducted by sending a seven item questionnaire to the manager responsible for psychiatric services in each district in England and Wales. The study did not undertake to examine the use of section 5(2) by non-psychiatrists. We disagree with Dr Kazeem's statement that it is quite clear who the nominated deputy should be in these cases. Should the nominee of a consultant physician be a junior physician who works for him or her, an on-call junior physician or the on-call consultant physician? Perhaps there is an