This survey was commissioned by the editors and was not intended to challenge editorial policy but to seek readers' views.

The editors believe that the interviews published in the *Psychiatric Bulletin* have been of much interest and value. A selection have recently been published in *Talking about Psychiatry* in which eloquent justification is made in the Preface as providing a unique perspective on British psychiatry. However, and this may relate to Dr Junaid's point in part, interviews have been traditionally conducted with eminent psychiatrists in retirement but are now to include colleagues who remain active and who have also distinguished themselves in other spheres as well as psychiatry.

EDITOR

Pharmacotherapy and wilful patient deception

Sir: The article by Dr Clarke (*Psychiatric Bulletin* 1993, **17**, 469–470) made interesting reading. The possibilities of adverse drug reactions in psychiatric patients are very real and can be overlooked. One factor not mentioned was the possibility of deliberate patient deception and, although infrequent, we feel it bears mention. Recently we encountered two patients with atypical symptoms related to this area whose behaviour proved hazardous to themselves and the treatment process.

One 30-year-old woman presented with ataxia and sedation while receiving treatment with antidepressants, and subsequently responded well to treatment as an in-patient. She later admitted using her child's methylphenidate and carbamazepine along with over-the-counter preparations. A second woman presented with bizarre neurological complaints during treatment with a tricyclic agent; the symptoms of meningism and headache persisted after the tricyclic was stopped. Later, she revealed that she was receiving oral retinoid therapy for acne but did not mention this lest the treatment was discontinued. Her subsequent response to treatment was good.

Patients may therefore wilfully mislead their psychiatrists on occasion especially regarding medication. The quality of the information we receive depends on a number of factors, and the use of over-the-counter preparations, herbal remedies and medications prescribed for others may jeopardise the patient and the treatment process. The fault may lie with the patient rather than the specialist who adheres too rigidly to his or her own area. The information may simply not be forthcoming despite exhaustive enquiry.

ALAN BYRNE, and GARY HNATKO, *University of Alberta, Edmonton, Canada*

Sexist case-notes can be useful

Sir: How sad that M. Phillips (*Psychiatric Bulletin*, 1993, **17**, 432) has revealed to the world the 'sexist' nature of medical record files kept at the Maudsley Hospital (women, buff colour; men, green). The reason for the differential colour coding has nothing to do with ease of retrieval etc (though this is commonly used as the pretext). It is, in reality, a subtle test of common sense for new Maudsley recruits. Common sense is a notoriously difficult ability to assess at interview and has no correlation with number of publications (O'Brien *et al*, unpublished observations on a frighteningly large and ever growing personal series). A registrar's 'time to realisation' that males and females have different coloured files is a reliable and valid measure which, in addition, never ceases to amuse those who have already attained this milestone. Although I do not have detailed figures to hand, I feel that the 18 months described by Dr Phillips is perilously close to being outside 2 standard deviations of the mean. However, Dr Phillips can be reassured in the knowledge that several leading academics (they know who they are) have failed to reach this goal without assistance from others.

On a more serious note, colour coded case-notes can be an invaluable part of the psychiatric examination. I became aware of such benefits when working in a clinic performing assessments on potential candidates for gender reassignment surgery. If potential male-to-female transsexuals appeared carrying buff (female) files after registering, they had demonstrated their ability to live successfully as the opposite sex, by fooling the reception staff. But if they failed to demonstrate 'O'Brien's sign', and walked in with a green file, then it was clear more work needed to be done before surgery could be considered. This simple measure, of which patients (like Dr Phillips) were blissfully unaware, saved hours of informant history gathering. Despite my experiences in the gender identity clinic, I remain convinced that important differences do exist between men and women. I would suggest that 'sexist' colour coding of notes is not only a reflection of this but can aid in psychiatric assessment.

JOHN T. O'BRIEN, *University of Melbourne, Clinical Sciences Building, Mont Park Hospital, Rosanna, Victoria 3084, Australia*

Day care in old age psychiatry

Sir: Dr Ball (*Psychiatric Bulletin*, 1993, **17**, 427–428) attempts a critique of day care in old age psychiatry. As in all NHS services, historical factors determine the development of services. The 'Worthing experiment' (Carse *et al.*, 1958) is perhaps the original demonstration of active treatment in a day hospital to prevent admission

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of older patients to a psychiatric hospital and was evaluated by Sainsbury & Grad (1965).

The central issue today is whether acute assessment, diagnosis and treatment can be carried out effectively and acceptably in a day hospital setting. Domiciliary visits, community mental health teams, in-patient units and out-patient care can be seen either as alternatives to such a service or as complementary. Geographical factors and pre-existing provisions often determine which of a number of options are chosen.

Our own experience of developing day care resulted from the need to bring distant and relatively isolated in-patient psychiatric units for the elderly into a compact urban catchment area.

A unit with nine beds and 20 day places was set up to replace one 24-bedded ward, serving a catchment area of 20,000 people over 65 years of age. From 1 January to 30 June 1993 this unit had 2,449 day attendances, had taken on 31 new day patients and 18 direct in-patient admissions. A further 15 patients required admission from day care over this period. Between 43 and 57 day patients attended weekly. An assessment of 60 patients from an earlier period does not suggest that the main problems are 'social', but that they have severe psychiatric problems; depressive, paranoid, delirious and manic in nature. Day care integrates with community nursing teams, primary care, social services and district general hospital liaison psychiatry.

Our experience concerning day hospital treatment is not unique. A survey of all districts in the South East Thames Region (Beats *et al*, 1993) suggests that the majority of old age psychiatric services perceive the need for day hospital treatment for primarily clinical reasons.

None of these facts, admittedly, prove that day care is more efficacious or provides higher quality care, neither is there any effective or proven research to suggest the superiority of the alternative to which Dr Ball alludes.

It would seem to us that it is dangerous, without evidence, to propagate these kind of views. In the present climate, where the needs of older patients with psychiatric disorder are increasingly described as being "social", the role of intensive psychiatric and medical assessment and treatment is in danger of being overlooked.

BEATS, B., TRINKLE, D. & LEVY, R. (1993) Day hospital provision for the elderly mentally ill within the South East Thames Regional Health Authority. *International Journal of Geriatric Psychiatry*, **8**, 442–443.

CARSE, J., PANTON, N.E. & WATT, A. (1958) A district mental health service, the Worthing experiment. *Lancet*, *i*, 39–41.

GRAD, J. & SAINSBURY (1965) An evaluation of the effects of caring for the aged at home. In *Psychiatric Disorders in the Aged*. Report of the Symposium held by the World Psychiatric Association at the Royal College of Physicians, London, 28–30 September 1965. Geigy (UK), Manchester on behalf of the World Psychiatric Association, pp. 225–236.

KLAUS BERGMANN and RAYMOND LEVY, *The Maudsley Hospital, London SE5 8AZ*

Sir: Bergmann & Levy bring a wealth of experience of working with the elderly mentally ill in day hospital settings to this debate. They describe the activities of their day hospital echoing much of the published work in this area. The architecture of their service is heavily reliant upon the day hospital setting and so it is unsurprising that they see many of their patients in this arena.

The hegemony of the day hospital is largely the result of historical processes. The welcome development of services for the elderly world-wide has not been matched by a similar growth in innovative thinking about models of service delivery or clear assessments of these models. This has led one set of investigators to conclude "various kinds of day care are available although their purposes are not always clear to clients or to service planners" (Wimo *et al*, 1993). It remains unclear under which particular set of circumstances a day hospital offers the best service to this group of patients or when an alternative approach may be of more value. Identifying these circumstances (e.g. particular patient groups, resources available for non-attenders, local social service arrangements and so forth) in a systematic way will begin to clarify this issue. It is unlikely that a single service paradigm will serve all needs and the balance of individual services will depend upon the local needs taking into account some of these variables.

I am unsure in what sense the views propagated in the original article (Ball, 1993) can be said to be dangerous. We share a common purpose in developing efficient, user-friendly and cost-effective services for our patients. As Bergmann & Levy suggest, there is little hard evidence to guide us in our choices. Developing services to work within the fabric of the patient's normal life represents a logical step in the progression from the "distant and relatively remote" units of the past.

It is a misrepresentation of my views to suggest that patients with mental health problems only have 'social' problems. While the social needs of this group have in the past not been accorded due weight (Murphy, 1992), the importance of psychiatric assessment within the multidisciplinary team framework cannot be understated. Only by working across the artificially imposed medical/social divide can truly rounded management plans be developed.

BALL, C.J. (1993) Day care in old age psychiatry. *Psychiatric Bulletin*, **17**, 427–428.

MURPHY, E. (1992) *After Asylums*. London: Faber.

WIMO, A., INEICHER, B., MATTSON, B. & KALLIOINEN, M. (1993) Assessment of productivity of psychogeriatric day care. *International Journal of Geriatric Psychiatry*, **8**, 675–680.

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