cases, provided appropriate supervision is maintained throughout the process.

We try to manage patients in their own environment, even in their homes, wherever possible.

The involvement of relatives has always been one of our prime considerations, either by holding regular group discussions or allowing them free contact to us on any of their problems relating to their mentally disabled relative.

A more recent development has been the formation of an interdisciplinary working group to give advice and make recommendations on 'Innovative Services for the Mentally Ill' in the community.

Most recently we concerned ourselves with the establishment of mental health centres where various professional disciplines from Health and Social Services join to provide some of the management, rehabilitation and resettlement of mentally affected persons in day or residential environments.

There are many more better known activities and functions undertaken by our community psychiatric services which need not be enumerated here.

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(See also Dr Freeman's article on pages 29–32.)

DEAR SIRS

I am apprehensive that recent developments to close many mental hospitals and the increasing bias towards community care may weaken the ability of the Mental Health Services to take appropriate steps to care for the patient with a mental illness.

A recent example will suffice to show that the resources of two hospitals and a possible third were necessary to cope with a crisis within one family. The family consists of mother, father, two sons and a daughter. One of the sons is severely mentally handicapped, the other son is suffering from a psychiatric disorder which resulted in a hospital admission under a court order. It is more than likely that he may be admitted to a State Hospital. The parents had not spoken to each other for some years and lived in different parts of the same house. The severely mentally handicapped son had been a hospital in-patient for about ten years because of severe feeding difficulties but with prolonged nursing care and medical help he had gradually gained weight and had reached a normal height and weight ratio.

About one year ago his mother began to exhibit early signs of a psychiatric disorder which resulted in her accusing the hospital staff of injecting her son with drugs to make him fat. She took him home and refused to return him to the hospital. He lived with his mother in a single room in the parental home. She refused to accept any help from the community services. His mother's condition deteriorated and recently her behaviour became so disturbed that she had to be admitted to the local psychiatric hospital for treatment, leaving only the patient's unmarried sister, who was six months' pregnant. His father would not offer any help. The boy was admitted to the local mental handicap hospital where he was found to be emaciated and suffering from severe iron deficiency anaemia with a haemoglobin of 4.2 gm per cent. He will require a great deal of skilled nursing and medical attention to return him to his previously robust good health.

This is an example that illustrates the need for the retention of core units of sufficient size so that they can meet the demands of society when the current mode of community care, however good, cannot do so.

I feel that it is a very good idea to care for people nearer their homes in the community, but there must be a core unit which can be relied upon to offer support and relief to the families, neighbours and society in cases of crisis.

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How to treat when neither 'mad nor bad'?

DEAR SIRS

The recent decision of the Mental Health Review Tribunal to release a patient detained under Section 3 of the 1983 Mental Health Act has prompted me to seek the views of other College members on the treatment of those who are neither 'mad nor bad'. This patient, and a number of others with similar difficulties known to me, would be regarded by psychoanalytically orientated psychiatrists as suffering from borderline personality disorder. This diagnosis, which can only be arrived at by close inspection of the personal relationships of the patient, comprises a chronic instability of personality, manifested by an angry attitude to others, relationships which oscillate between idealization and denigration, transient loss of reality testing under stress, and an extraordinary capacity to split groups of staff into warring factions.

Such people fail to respond to conventional medical treatment, and yet are clearly not sociopathic. They almost invariably cause a major management problem with episodic violence and chaotic personal relationships. Frequently the capacity to control their management is the only therapeutic tool at our disposal. In the case of this particular man, it will be quite pointless readmitting him to hospital since we cannot treat his condition without compulsory powers, and in terms of the Act he is not ill.

My concerns are twofold:

(1) If he and others like him are to be treated in hospital, they will go to prison when, quite clearly, not responsible for their actions.

(2) Why do we insist on subscribing to an obsolete system of classification, which makes no allowance for the people we actually see, many of whom, like him, fall between two stools.

Comments, please!

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