me, and to whom I should address myself. I turned my chair towards the Judge and spoke slowly to him from then on. He seemed a pleasant, benign, attentive man, listening to my every word. He suggested I be asked for my opinion on events which had happened since my last contact with the family and adjourned the court while I read the relevant affidavits. I gave my opinion, was thanked by the court, and dismissed. Once more I headed into the bright afternoon sunshine. The ordeal was over, I was now, for future reference, an expert witness. However, I felt myself to be but a small cog in a very big wheel.

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Mental health review tribunals

DEAR SIRS

Dr Grounds has performed a very useful service in pointing out the difficulties and contradictions in the work of the Tribunals (*Psychiatric Bulletin*, June 1989, **13**, 299–300).

There is one problem that I have not seen publicly aired, that is that discharge from a Restriction Order by a Tribunal also means discharge from hospital. The Act seems to make an assumption that anybody under a Restriction Order is anxious to leave hospital as soon as possible.

This is not always the case and there are patients who would benefit from being discharged from their Order and remaining in hospital informally by their own decision. This step in the rehabilitation of certain patients involving the development of autonomy can be an important one and is not, apparently, addressed by the Act.

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'Asylum': a new magazine

DEAR SIRS

We were heartened to read Peter Tyrer's review, entitled 'Arming the Weak: the Growth of Patient Power in Psychiatry', of *Power in Strange Places: User Empowerment in Mental Health Services*, edited by Ingrid Barker and Edward Peck (*Psychiatric Bulletin*, June 1989, **13**, 307–308). It was considered and valuable. We agree that "it is much healthier for (patient power movements) to be involved in regular dialogue with the professionals rather than externalised and largely ignorant of other points of view". One could perhaps add that it is for the professionals to try to render themselves less ignorant about the views of patients. We believe that patients must have a strong voice and power to be able to alter psychiatric practice. It is mistaken for us to believe that we know in all cases what is good for others; if psychiatry could actually cure many of the so-called illnesses that we come across, this would be more understandable.

We are currently involved in attempting to produce a new Master's programme for practitioners, patients and others on 'Psychiatry, Philosophy and Society'. This is primarily intended to equip the practitioner with a critical faculty such that those involved will be able to deal with the very wide-ranging debate around issues of power in psychiatry; for things to change in practice, most of us need to start thinking differently. We have tried to democratise our own service and are hoping to develop greater contact with user movements. Part of this process has been setting up a magazine for democratic psychiatry known as '*Asylum*'. Some of the members of our department are currently members of its editorial collective. It is a magazine that is dedicated to an open debate and to enhance a dialogue between workers and users so that both sides can see what the other is saying and have a chance to respond. Many varied views are published, activities of user groups advertised, bad practices highlighted, and there is regular space for the critics of psychiatry to put their case. There is space for more orthodox views. Sadly, professionals seem unenthusiastic about this debate and rarely send articles. Many of the user groups such as Survivors Speak Out, the Campaign against Psychiatric Oppression, the Network for Alternatives to Psychiatry and many others, on the other hand, have used our '*Asylum*' magazine.

We would like to propose that *Asylum* could be an excellent vehicle to achieve some of the aims, and more, that Peter Tyrer attempts to delineate in his review. It is a non-profit making, and frequently a loss-making, magazine although it is read quite widely throughout the country by patients and workers. We think it would go a long way towards bridging some of the gaps between patients and professionals if members of the Royal College of Psychiatrists could make more regular contributions to such a journal and engage in some of the debates that patients wish to initiate around issues such as patient power, the Mental Health Act, the validity of treatments, access to notes, the position of particular client groups, including those arranged in terms of class, sex and race, client-led research and client control. We think that the Royal College of Psychiatrists and its Members and Fellows could usefully subscribe to this magazine to find out what patients' views really are. *Asylum* would obviously have to remain structured in the way it is for patients to feel they could trust such a magazine. The editorial collective is open to all comers but clearly would fear a professional takeover.

Perhaps the Royal College of Psychiatrists and the *British Journal of Psychiatry*, and other interested parties, could collaborate with *Asylum* and the survivors' movements etc. to initiate conferences or symposia run by users and workers to explore some of the issues outlined above. Both undergraduate and postgraduate training, in our view, should involve some time spent considering, and perhaps even testing, the political and social issues involved in psychiatric practice and the rhetorical and theoretical justifications for such practices. We believe that there should be a curriculum for the training of psychiatrists that is influenced by user groups. To be able to deal with such varied inputs, psychiatrists would need some background training in political and social studies and philosophy, and they should be strongly encouraged to develop a critical faculty. Not one of us can see clearly our position in the world of psychiatry and psychiatric practice, but what we can do is to see dangers and approach such dangers with courage and a real desire to sort these things out. Psychiatrists need to have a grounding in 'problematics'.

It is unfortunate that many patients and patient groups, not unreasonably, believe that doctors see themselves as almost infallible. Patients frequently experience doctors diagnosing them as fundamentally different from the rest of society and fundamentally different from the doctor. Many doctors believe this too. More unfortunately, doctors are often quite unaware of the effects of what they do in terms of patients' lives, feelings and activities.

When Peter Tyrer says that the user movement "in psychiatry is now a healthy and aggressive toddler, but if we ignore its development it could well show signs of delinquency", we hope we understand him correctly. Blind indifference and calculated ignorance will be as damaging as active opposition to the users' movements; patients engaging in battle with psychiatrists is perhaps a mass sickness that psychiatrists really could cure.

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Residential units for families

DEAR SIRS

'The Treatment of Child Abuse in an In-patient Setting' (*Bulletin*, September 1988, **12**, 361–366) brings to light the possibility of offering help to families that are difficult to help in the conventional outpatient and community settings. The Cassel Hospital unit, however, is not the only medical establishment with in-patient beds for whole families (Brendler, 1987; Haldon *et al*, 1980; Lynch *et al*, 1975). In Portsmouth we have two such units, one of which has been in operation for 14 years, and it caters for families which need intensive treatment over long periods of time. The other one caters for families that need intensive treatment over shorter periods of time.

Our units cater for a wide spectrum of emotional problems; behavioural disorders, emotional deprivation, severe multiple non-accidental injuries, childhood psychosis, adult psychosis infanticide, children at risk of non-accidental injury, multiple problem families, intractable cases of enuresis and encopresis. The duration of hospitalisation in the long term unit varies from two months to 18 months with an average stay of five months, and in the short term unit, from three weeks to 12 weeks with an average stay of seven weeks.

The treatment programme in our units is similar to that described at the Cassel Hospital but with the emphasis on team assessment based on pre-admission one day assessment and one to four weeks assessment/observation in hospital. The treatment programme is tailored for each family and treatment methods include family therapy, individual therapy for adults, individual/play therapy for children, behavioural therapy, parent's group, video feedback, art therapy, marital counselling, information/education, activities of daily living, medications, hypnotherapy, dance therapy and regression therapy. We maintain close liaison with the community network.

Attachment theory (Bowlby, 1969; 1973) is found useful, both in understanding and helping families. If we understand parents as people who fail to make secure bonds with their own attachment figures and are consequently unable to be adequte attachment figures for their own children, then we strengthen the parents enough so they can become the attachment figures for the children. At the same time we work with the children to make them amenable to bonding to their parents. If we fail to strengthen the parents then we try to get the children to attach to the staff in the unit and then transfer the attachment to a foster/adoptive family.

We agree that treating such families is a long-term investment for society in that it saves resources that would have to be spent on fostering, children's homes, legal circles and drainage of the health resources. Even in cases where the outcome is separating the children from the parents, our continued support for the children to settle in new families and for the parents to let go of the children helps to cut the cycle of deprivation.

We agree that it is difficult to predict which families will benefit most from such treatment. In our unit it is intuitive, and if as a team we feel we have something to offer we try. It is not scientific but we make no apology.