other patients. When not in use the observation area is locked off and not staffed.

The creation of such 'observation areas' is dependent on the institution having adequate space to put aside a lounge area for only intermittent use. This capability may be lacking in facilities where space is at a premium. The concept is, however, worth exploring further, as any mechanism which lessens the need for seclusion is highly desirable.

C. M. GREEN

Norvic Clinic
Norwich NR1 4LJ

Diogenes syndrome

DEAR SIRS

The description given by Drs Anderson and Bach-Norz (*Psychiatric Bulletin*, 1991, **15**, 574) of an elderly woman living in extreme squalor, hoarding objects for no useful purpose and refusing all offers of help sounds like that of the Diogenes syndrome.

An individual showing the syndrome is typically untidy, unsavoury and often insanitary and psychiatrists may be asked by social workers, housing departments, general practitioners and/or neighbours to take away such a blot on the landscape.

My own belief is that psychiatrists should treat the sick and not act as agents of social control. If this lady presents a danger to the public health or to the safety of buildings then these dangers can be readily dealt with by well established procedures without any need to invoke the Mental Health Act perhaps inappropriately. It may be that her house has not been made safe because the relevant authorities do not want her to return to it and much prefer to have her out of sight.

On an entirely separate point, may I ask what is the difference between deceit and deception. My dictionary gives "deceit – act of deceiving" and "deception – act of deceiving".

D. V. COAKLEY

Whiston Hospital
Prescot, Merseyside L35 5DR

Psychiatry in war

DEAR SIRS

I was pleased to learn that my former colleague, Dr Gamble, returned safely from his exploits in the Gulf (*Psychiatric Bulletin*, 1991, **15**, 505). He trusts that the NHS will "have little to do in the wake of this war". Those of us serving with the Forces at the time of the Falklands war remember similar sentiments being expressed then about the apparent lack of psychiatric casualties, but we now know that the hidden morbidity was substantial (James & Lovett, 1987).

Since leaving the Army, I have come across many anecdotal case reports from civilian colleagues treating Falklands veterans suffering from psychological problems consequent upon that war. I have also personally seen many veterans from past wars who never came to formal psychiatric attention at the time but suffered nevertheless, helped where possible by the Ex-Services Mental Welfare Society. I would think it unlikely that the Gulf War will be different in this respect. Many soldiers will have been involved in burying large numbers of Iraqi dead, and this places them at risk in a similar way to those of the rescue services who dealt with the dead from the Zeebrugge, Lockerbie and Kings Cross disasters.

The Gulf war has already had an impact on my work. Several patients, veterans of past conflicts, reported an increase in intrusive memories and flashback phenomena when the Gulf war was at its height, provoked by the vivid television images from the desert. I suspect that my experience here is by no means unique. I would be surprised if in time, further work more directly related to the Gulf conflict does not come the way of NHS practitioners.

G. E. VINCENTI

Rutson Hospital
Northallerton
North Yorkshire DL7 8EN

Reference

JONES, G. & LOVETT, J. (1987) Delayed psychiatric sequelae among Falklands war veterans. *Journal of the Royal College of General Practitioners*, **37**, 34–35.

A list of experts who can give advice to individuals suffering from post-traumatic stress disorder resulting from situations such as the Gulf War is available from Vanessa Cameron at the College.

Services the consultant in mental handicap provides

DEAR SIRS

In recent years the demedicalisation of mental handicap has raised the questions of what the consultant in mental handicap does and where there is a need for such posts. From the points of view of practical work, audit and business planning, it is useful to record what tasks and services can be performed or provided only by the consultant. The following pilot list shows that there is still a range of activities that only the consultant can do.

Psychiatric history taking, examination, assessment, diagnosis, treatment, prognosis, of outpatients referred by general practitioners, other consultants and community services; responsibility for overall treatment of in-patients under the consultant's care and co-ordination of their rehabilitation, resettlement and discharge; provision of psychiatric notes, reports, letters, including reports

https://doi.org/10.1192/pb.16.2.111-b Published online by Cambridge University Press

for Police, Probation Service, solicitors and courts; prescription of medicines; classification of patients, e.g. ICD; medical certification, eg, fitness for work, consent to treatment, death certification; provision of certificates for the Court of Protection, e.g. CP3; Responsible Medical Officer, 'RMO', duties and commitments; completion of documents under the provisions of the Mental Health Act by consultants approved under Section 12 of the Act; completion of reports for Mental Health Review Tribunals, including Second Opinion reports; provision of psychiatric evidence as professional witness in Court, including attendance at inquests; teaching generally on medical aspects of mental handicap; supervision and training of junior medical staff and senior registrars; psychiatric and medical research; provision of consultant cover for colleagues on leave or absent; participation in medical audit; psychiatric advice on service needs, development, planning and staffing for management; attendance at professional meetings and committees; and work in connection with professional organisations, e.g. The Royal College of Psychiatrists.

D. A. SPENCER

Meanwood Park Hospital
Leeds LS6 4QB

Psychiatric referrals to emergency clinics

DEAR SIRS

Recent publications in the *Psychiatric Bulletin*, Gee (1991) and Haw *et al* (1987) have examined the issue of psychiatric referrals to emergency clinics. The proper assessment and management of crises and avoidance of hospitalisation when appropriate is important, especially in these days of increasingly limited NHS resources.

Our hospital recently carried out a survey of patients presenting on an urgent basis to the duty psychiatrist over two months in an effort to audit the use of this avenue of referral.

In total, 131 patients were seen as urgent referrals. We found that 70 (53%) of the patients seen had referred themselves v. 33 (25%) who were referred by their general practitioners. The remainder of patients had been referred by other agencies (police, social work department, Alcoholics Anonymous, etc).

Interestingly but not unexpectedly, we found that GP referrals were more likely to require urgent admission when compared to self-referrals: 24 of the 33 GP referred patients required admission (72%), v. 20 of the 70 self-referred patients (28%).

There were more self-referrals outside working hours: 46 of the 70 self-referrals (66%), and the admission rate for patients who self-referred rose as the day progressed. Of the 24 self-referrals seen from 0900–1700 hours, four required admission (16%). Eight of the 28 self-referrals seen from 1700–2400 hours required admission (28%). Six of the 18 self-referrals seen from 2400–0900 hours required admission (33%). Similar trends were not evident in the GP referred population.

These findings raise several interesting questions which require further investigation. Are patients good judges of their need for acute psychiatric help? Are patients more unwell at night, or does the duty psychiatrist's threshold for admission change as the day (and night) progresses? Is the level of training of the duty psychiatrist an important factor? Do patients abuse a psychiatric emergency service because it is so freely accessible? Is a 24-hour 'walk-in-as-you-please' service a luxury in our current NHS?

GRAINNE NEILSON

Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

References

GEE, M. (1991) Self referral admissions. *Psychiatric Bulletin*, **15**, 329–330.

HAW, C., LANCELY, C. & VICKERS, S. (1987) Patients at a psychiatric walk-in clinic – who, how, why and when. *Bulletin of the Royal College of Psychiatrists*, **11**, 329–332.

Patient involvement in their psychiatric care

DEAR SIRS

Dr Pilgrim (*Psychiatric Bulletin*, 1991, **15**, 370) should be reassured that considerable advances have been made with regard to patient involvement in their psychiatric care, and the issues he raises are already being seriously addressed by the profession.

We wish to make the following points in connection with the issue he raises.

(a) Consent to treatment is an issue which is afforded the highest importance in psychiatry, in which it is well recognised that mental illness raises particular problems in this respect. The Mental Health Act Commission has examined this issue and a Working Group of the College has reported on this subject in relation to patients with impaired volition.

(b) Physical treatments used in psychiatry do have powerful effects, both beneficial and adverse. We believe that any debate about the risks of treatment must also include examination of the extensive evidence as to the beneficial effects, as well as the risks of untreated serious mental illness.

https://doi.org/10.1192/pb.16.2.111-b Published online by Cambridge University Press