we knew what was right and wrong. We cling to our point of view, as though everything depended on it. And yet our opinions have no permanence: like autumn and winter, they gradually pass away..."[2]

"Perfect is the man who knows what comes from heaven (spiritual knowledge/wisdom) and what comes from man (wordly knowledge/science). Knowing what comes from heaven, he is in tune with heaven. Knowing what comes from man, he uses his knowledge of the known to develop his knowledge of the unknown and enjoys the fullness of life until his natural death. This is the perfection of knowledge. However, there is one difficulty. Knowledge must be based upon something, but one is not certain what this may be. How, indeed, do I know what I call heaven is not actually man, and that what I call man is not actually heaven? First, there must be a true man; then there can be true knowledge".[3]

These perspectives can perhaps be reconciled in the words a psychoanalyst supervisor once spoke to me, "Analysts may not be scientists in the strictest sense of that word; but they are certainly to be found among the lovers of science. For themselves and their patients, what they seek is the truth."

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REFERENCES

[1]CHUANG TSU *Inner Chapters* Trans. (1974) Gia-Fu Feng & Jane English. London: Wildwood House. Chapter Three 'The Secret of Growth'.

[2]Ibid Chapter Two 'The Equality of All Things'.

[3]Ibid Chapter Six 'The Great Master'.

Meeting potential colleagues

DEAR SIRS

There appears to be some confusion over the protocol for meeting with potential colleagues when applying for a new post. One such applicant for a consultant post was severely criticised for failing to see such colleagues, although it later transpired that he had been advised that this would be seen as canvassing. Under these circumstances it might seem sensible to lay down what should be acceptable practice in this situation to help steer candidates between the risk of appearing to canvas or alternatively appearing apathetic.

As some posts may receive up to 60 applications it would be futile for all such applicants to attempt to meet all their potential colleagues. On the other hand they should certainly make sufficient enquiries to be sure the post is one they wish to pursue and it would also be sensible to meet with one of those responsible for short listing. Once the short list has been drawn up the candidate would be well advised to make himself available to meet all such colleagues as would wish to avail themselves of the opportunity. The candidate should not have attempted to meet with those on the interviewing panel who could be seen as outside assessors.

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Discharges by Mental Health Review Tribunals

DEAR SIRS

It will be interesting to learn whether Dr Bermingham's promised further investigation (*Bulletin*, March 1987, 11, 96–97) into discharges by Mental Health Review Tribunals has included an examination of the extent to which Section 2 is used when Section 3 would be more appropriate. It is understandable that, when put in the position of needing to use the Mental Health Act 1983, those involved would prefer to exercise what is seen at that point as the minimum duration of detention. Nevertheless, Section 2 relates to the need for assessment, or, put another way, that the diagnosis is not initially sufficiently clear for definitive treatment to be offered without a period of clinical fact-finding. Yet, to judge by the thickness of the case-notes of the greater majority of patients admitted under Section 2, the diagnosis is already known, and the patient's treatment and management predictable.

There is no more difficulty in discharging a patient from Section 3 than from Section 2; Section 3 permits whatever time is necessary to arrange for after-care; the patient can even be sent on leave if lapse or relapse is thought likely, and the distasteful phenomenon of repeated use of Section 2 is avoided. The multidisciplinary hassle and aggravation of potentially harmful haste induced by application to the Tribunal by a patient under Section 2 does not occur.

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The legal aspects of psychiatry

DEAR SIRS

Few psychiatrists with many years in practice will have not sought medico-legal advice at some time. As the service changes more issues with legal implications arise. Existing sources of medico-legal advice may be well able to assist psychiatrists with relatively uncomplicated queries. For the more complex matters psychiatrists may be left with the impression that their advisers are sometimes not completely *au fait* with the difficulties and problems which are more specific to psychiatric work in general and in its subspecialties.

For example, questions not infrequently arise about the ownership of, the copying of, and the availability to others, of psychiatric case files, including computer records, confidentiality, and responsibilities of multi-disciplinary team arrangements. The transfer of patients from mental hospitals to care in the community is exposing uncertainties about the legal responsibilities of hospital authorities, consultants, the rights of patients and the obligations of relatives.

Among the various interests which the Royal College of Psychiatrists pursues, the legal aspects of psychiatry do not appear to be represented by any distinct department or sub-

group of the College. Forensic psychiatry, the application of psychiatry to the purposes of the law and the administration of justice, is a different and separate entity. In recent years voluntary agencies for mental health, for instance, MIND, in its publications, and the new Mental Health Act Commission, have emerged as taking a lead in seemingly paying more attention to the legal aspects of psychiatry than the College.

There would appear to be an opportunity for the College to fill the gap and to take the initiative with the establishment within the College of a special branch to develop studying experience, expertise, information and advice in the legal aspects of psychiatry, perhaps drawing in the collaboration of the Medical Defence bodies, the Mental Health Act Commission and voluntary health organisations.

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National Demonstration Services

DEAR SIRS

Members of the College may know that the DHSS has designated eight psychiatric rehabilitation services as National Demonstration Services (Hollymoor, Prestwich, Nottingham, Northampton, St George's (Morpeth), the Maudsley, Netherne and Southampton).

The co-ordinators of these National Demonstration Services met last summer and produced a joint statement expressing deep concern about the impact of management changes and financial stringency on services for the chronic mentally ill, despite Government commitment to giving priority to these services.

The co-ordinators see the problem as arising at Regional level where, despite all protestations to the contrary, the run-down of mental hospitals has become a primary objective dictating the extent and pace of resettlement in the community.

This detailed statement was forwarded to the National Health Service Management Board on 26 August 1986 and we are concerned that to date, it has not even been acknowledged. We feel that the issues are of concern throughout the psychiatric services and we ask you to publish the statement to bring it to the attention of members of the College.

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STATEMENT ON PSYCHIATRIC REHABILITATION AND CARE IN THE COMMUNITY

To The NHS Management Board

From The Co-ordinators of the National Demonstration Services for Psychiatric Rehabilitation

Psychiatric services are facing considerable problems during this period of change in the National Health Service linked with financial stringency. Services for the chronic mentally ill are affected in various ways and even some of the National Demonstration Services for Psychiatric Rehabilitation report problems in maintaining their services in spite of their reputation for excellence.

1. *Nature of specialist rehabilitation teams and National Demonstration Services*

National Demonstration Services for Psychiatric Rehabilitation were introduced by the DHSS in 1981. It was a condition of desigation that they should be nominated and supported by their local District and Region. As models of good practice, part of their function is to provide an advisory, planning and education service to their Region. Their designation was based on evidence of a commitment by a skilled multi-disciplinary team to looking after the interests of people with chronic psychiatric disabilities.

Effective, economical and efficient services are hallmarks of the National Demonstration Services and are consistent with the aims of General Management. The National Demonstration Services are an invaluable resource to Management (particularly at Regional level) in the planning and delivery of services and should lead the way in showing how rehabilitation can be provided effectively to the benefit of patients and thus to the Health Service. The NHS Management Board will want to encourage full use of these valuable resources.

The educational value of these services to managers and clinical teams deserves recognition. For example, there is a myth that rehabilitation is a 'once and for all' phenomenon, i.e. that once patients are 'rehabilitated' they will stay well and function independently for many years. It is quite clear that this is not the case without considerable care over a long period and in many cases for life.

There is another myth that rehabilitation is only related to the closure of mental hospitals and has no place in a community-based mental health service. It is worth stating that psychiatric rehabilitation services have a vital role in reducing the disablement of people with chronic mental illness and thus their dependency on the NHS and other welfare services. Nevertheless, people with chronic disabilities will continue to need substantial support. The most disabled will still require prolonged hospital treatment and care. Regional objectives for mental health services will only be met if rehabilitation services are strengthened and given proper resources so that they can proceed with their task expeditiously.

An effective rehabilitation service depends on a trained specialist multi-disciplinary team whose members undertake a long-term, full-time commitment to a population of chronic patients who present recurring or continuous clinical and social problems. Such services also rely on the development of chains of linked occupational, residential and leisure-time provisions, which are properly co-ordinated and which include a comprehensive view of the patients' disabilities and assets at different times and which permit easy movement of patients through different levels while maintaining continuity of care.

It follows that adequate liaison between the team and the statutory (e.g. Health, Local Authority and Employment Services) and voluntary bodies has to be actively main-