requirement for regular multidisciplinary review and because of the time consumed in preventing drop-out. We wish to reserve it for LTMI patients while continuing to treat acute or minor disorders in the cheaper, traditional out-patient setting. To divide our work in this way, we need a working definition of the LTMI patient. The literature offers little that is adaptable to our use. Bachrach (1988) proposes the admirable principle that definitions of the LTMI should include three parameters: diagnosis, duration and disability. Most research criteria are too exclusive for use in a service setting. We are working with the following definition which we offer here for comment.

DEW definition of LTMI patients 1988

Any one of the following specifies inclusion in the LTMI category:

(a) two or more years continuous contact with psychiatric services – including out-patients
(b) depot medication prescribed
(c) ICD diagnosis 295.X or 297.X
(d) three or more in-patient admissions in past two years
(e) three or more day-patient episodes in past two years
(f) DSM-III "Highest level of adaptive functioning in past year" rating 5 or more.

Having allocated a patient to this category, we specify the following minimum intervention for his keyworker:

DEW case management checklist for LTMI patients (1988)

(a) He cannot be allowed to drop out of follow-up.
(b) We perceive him as a patient needing regular review in a multidisciplinary discussion. (Specifically, out-patient care by one person or CPN care by one person is unlikely to afford him the best that this district can offer.) He therefore must be regularly reviewed in community team meetings.
(c) We foresee major problems of poor motivation in attempting to provide him with community support. For this reason assertive outreach, including personal help with attending appointments or events, is appropriate.
(d) Subject to his consent, one member of the team must make a home visit. (Home visits are the norm for patients with psychoses but some of the very disabled neurotic LTMI patients are longstanding out-patients and have not, in the past, been seen at home.)
(e) If he moves into the intensive care of another agency we must maintain contact, at least at three month intervals.
(f) If he refuses both our service and social services intervention, we will jointly attempt some follow-up via families, neighbours or friends, at least at three month intervals.

DEW is using the LTMI definition and the case-management checklist in a service context. We have neither the rigorous intake criteria of a research project nor the three year time scale of many demonstration projects. Consequently, we use the definition in a rough and ready manner. Over the passage of years some patients change unexpectedly. A few whom we have designated LTMI have made surprising recoveries and achieved discharge. A few others have eluded our most strenuous efforts to maintain three monthly contact. Nevertheless, we find the definition a serviceable tool for our purposes and should welcome a debate in your columns about its refinement.

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MIND Special Reports

DEAR SIRS

It must appear churlish for an author to write to your journal to complain about a favourable review of his work by a learned professor of psychiatry (*Psychiatric Bulletin*, November 1988). However, in his positive review of the MIND Special Report *ECT Pros: Cons and Consequences*, Professor Brandon chose to cast slurs unsupported by reason or argument against other unspecified Special Reports in the MIND series. For his information there are four other Special Reports: *Minor Tranquillisers: Hard Facts Hard Choices*, *Anti-depressants: First Choice or Last Resort*, *Major Tranquillisers: The Price of Tranquillity*, and *Lithium Therapy: Questions of Balance*.

MIND Special Reports are based on close readings of the relevant literature, advice from eminent academics and practitioners in the field and on the experiences and views of the people who receive the treatments in question. I strongly suspect that Professor Brandon has not read the Special Reports which he dismisses so lightly. I challenge him to do so in order that I may learn from his reasoned

arguments and in the interests of a better quality of debate on important issues.

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DEAR SIRS

I always read with interest the Special Reports published by MIND and am familiar with those mentioned by Mr Lacey.

Like many other psychiatrists, however, I sometimes feel that MIND, both national and local, campaigns with a zeal which does not always recognise the real constraints that the mentally ill, their families and their psychiatrists have to work within.

In some campaigns both ECT and drugs have been roundly condemned when what is needed is greater discrimination in their use. The report on ECT recognised that and I applauded it.

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Training assessment visits

DEAR SIRS

As most of your readers are well aware, the Joint Committee on Higher Psychiatric Training lays a very strong emphasis on trainee representation on its visits to senior registrar training schemes. In the past such representation has sometimes been restricted to trainees from a few training schemes. In order to widen this representation, may I, through your correspondence columns, urge senior registrars to forward their names to me for inclusion on training assessment visits. Trainees' participation in such an exercise is vital if the improvement in their training is to continue. Participation in such visits enables one to not only understand how the other half lives but also gives invaluable insight into one's own training.

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Groups in a mental handicap hospital

DEAR SIRS

I read with interest Dr Lovett's article on 'The Life of a Group on a Locked Ward' (*Psychiatric Bulletin*, February 1989, **13**, 60–62). I was involved with two similar groups in a mental handicap hospital; a group each on a male and female ward with behaviourally disturbed patients with mild to moderate handicap.

Some of the difficulties outlined by Dr Lovett were apparent in the above groups. In particular, there were difficulties about the same nurses attending each week due to their shifts. In addition, patients would walk in and out of the group, and due to poor punctuality on both patients' and staffs' parts, the group would often commence late.

I experienced other difficulties also. Firstly, there was difficulty in making interpretations and following the group process in view of patients' mild and moderate handicap. Secondly, the ward staff adopted an approach whereupon patients were requested not to express negative views. It was difficult to persuade the experienced ward staff to change their long-standing views.

Despite the difficulties, the groups appeared to be useful and valuable. The conclusions reported by Dr Lovett appeared very appropriate.

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