DEAR SIRS

I agree with Chris Green (*Psychiatric Bulletin*, August 1992, **16,** 511–512) that in practice juries are more influenced by intangibles than by the application of the definition of diminished responsibility in the Homicide Act 1959. When I was examining a number of offenders at the request of both the prosecution or the defence, I became increasingly convinced that the more sensational and horrific the alleged offence the less likely the jury was to accept evidence of diminished responsibility, however overwhelming this appeared to be from a psychiatric point of view. As a result, I came to believe, as others before me, that juries' own responsibilities should be substantially diminished and limited to deciding guilt or innocence on the basis of the evidence presented to them and that, in the event of the former verdict, any consideration of the offender's mental state should be by a panel similar to a Mental Health Review Tribunal hearing appeals by restricted Section 37/41 cases – a view which I submitted in written evidence to the Royal Commission on the Criminal Justice System.

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Mental health services in Brighton

DEAR SIRS

We read with interest the views of John Mahoney on resources for developing mental health services (*Psychiatric Bulletin*, August 1992, **16,** 490–492).

While we agree with the significant role which districts and regions need to play in providing bridging finance for services in transition, caution needs to be applied to using unit costs as an indication of available resources.

Although Brighton was indeed in the top 10 of high unit costs in the survey of 57 institutions in 1983, the unit referred to only had 42 beds and therefore this did not mean that Brighton had a large budget for mental health services to reallocate!

In fact, the development of a comprehensive community based mental health service in Brighton since 1983 has been mainly achieved by the transfer back of 100 people from out of district large institutions. The majority of these came from one hospital which was not even in the same region as Brighton and only marginal costs were transferred with each patient. The bridging funding then provided by South East Thames Regional Health Authority did greatly assist with enabling Brighton to achieve its service developments. However, this year we are transferring back a further 40 people to community based residential services in Brighton. We will achieve this without the benefit of any capital funding from either district or region, but through making the maximum use of our good working relationships with the local Social Services and housing associations.

The decision to proceed with this new reprovision programme was only made in September 1991 and at least 20 people will move to their new homes in November 1992.

While agreeing with the relevance and importance of all the issues which John Mahoney identifies, three other key issues are: the use of sensible staff skill mix (using trained but not necessarily professionally qualified staff in residential services); actively supporting the development of a local mixed economy of care; and management and clinical determination and drive which are able to exploit all possible avenues and maintain the momentum of change with quick and responsible decision making.

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Relatives who refuse to given consent

DEAR SIRS

I read with interest the letter from Sean Scanlon (*Psychiatric Bulletin*, August 1992, **16,** 513–514) and would like to make the following comments.

(a) Dr Scanlon comments that it should be enough to do all one can, and there is no need to feel helpless. This is naive. When a patient is mentally ill, and treatment is being withheld because of the view of the next of kin, I suspect most reasonable psychiatrists would feel helpless.

(b) The author says that the process of displacement of next of kin is not long and complicated and to support this incorrect claim gives the reasons why it should be!

(c) He uses one example to support his claims. I suggest that his experience is the exception and would like to hear other peoples' experience of this issue.

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Ranking of therapeutic and toxic-side effects of lithium carbonate

DEAR SIRS

Dr Colgate is to be congratulated on (*Psychiatric Bulletin*, August 1992, **16,** 473–475) drawing attention to the lack of clarity in prescribers' information for lithium medication.

The bad publicity which lithium medication has accrued is more a reflection of bad practice than a problem with the medication. The British National Formulary (BNF) and monthly index of medical specialties (MIMS) have unwittingly contributed to the confusion by retaining out of date information. For example, the kidney scare of the '70s has now been discounted (Waller & Edwards, 1989). Yet the BNF still lists kidney changes as a side effect of therapeutic use quite separately to polyuria. It is not clear what kidney changes are referred to. MIMS states that "treatment should be initiated in hospital". Such alarmist reactions are outdated and do not reflect current specialist opinion.

We have published a guide to prescribing which should facilitate safe practice and confidence building (Srinivasan *et al*, 1992).

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Prescription charges and recurrent depression

DEAR SIRS

Following the publication of Dr Vincenti's letter (*Psychiatric Bulletin*, July 1992, **16**, 444) suggesting that sufferers from recurrent depression should be exempted from prescription charges, this matter was considered recently by the College's Executive and Finance Committee. Under the present system, individuals suffering from certain chronic medical conditions are entitled to receive free NHS prescriptions, although this does not extend to include patients suffering from long-term mental illnesses.

The British Medical Association's General Medical Services Committee has undertaken a review of the arrangements for prescription charges in response to many complaints both from patients and from the profession that the present system is inequitable and anomalous. The College's Executive and Finance Committee shares the view expressed by the British Medical Association that the present level of charge may act as a disincentive to some patients in obtaining necessary medical treatment. However, the Committee also accepts the view that any extension of the present exemptions would be likely to introduce further anomalies, and raise disproportionately the burden on those paying charges. For this reason we would support the British Medical Association's position that the present system be revised, and the overall burden of charges be spread more equitably. The British Medical Association is currently considering making an approach to the Department of Health on this issue, and I would propose that this be supported by the College.

Professor A. C. P. SIMS
President

Attendance at multidisciplinary case meetings

DEAR SIRS

Your anonymous correspondent (*Psychiatric Bulletin* July 1992, **16**, 445) highlights an area that we have long considered cause for concern. His finding, that on his own unit, over three-quarters of multidisciplinary care meetings proceeded in the absence of at least one ward or community key-worker does not surprise us. In fact it accords perfectly with experiences we gained during our rotational training as registrars. We have also made the further observation that there appears to be an inverse relationship between multidisciplinary staff attendance at so-called "staff groups" and attendance at case meetings where the welfare of actual patients is supposedly advanced. Psychiatrists are of course far from perfect, but we do seem to indicate that we take our responsibilities for the welfare of our patients seriously by at least attending care meetings, be they ward or management rounds or case conferences. We can only hope to inspire members of other disciplines by our shining example in this respect or at least shame them by raising the issue at the next meeting of the navel-gazing unit staff group!

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Sporting philias

DEAR SIRS

I am deeply grateful to Dr Barrett for his brave and self-revelatory piece (*Psychiatric Bulletin*, July 1992, **16**, 454). As a long-term sufferer from the same syndrome, with intermittent remissions occasioned by examination neurosis, marital disharmony, and "child care and the growth of love" (à la Bowlby) I too have grappled with this disorder. Treatment is difficult, but one should perhaps accept the positive side.