of older patients to a psychiatric hospital and was evaluated by Sainsbury & Grad (1965).

The central issue today is whether acute assessment, diagnosis and treatment can be carried out effectively and acceptably in a day hospital setting. Domiciliary visits, community mental health teams, in-patient units and out-patient care can be seen either as alternatives to such a service or as complementary. Geographical factors and pre-existing provisions often determine which of a number of options are chosen.

Our own experience of developing day care resulted from the need to bring distant and relatively isolated in-patient psychiatric units for the elderly into a compact urban catchment area.

A unit with nine beds and 20 day places was set up to replace one 24-bedded ward, serving a catchment area of 20,000 people over 65 years of age. From 1 January to 30 June 1993 this unit had 2,449 day attendances, had taken on 31 new day patients and 18 direct in-patient admissions. A further 15 patients required admission from day care over this period. Between 43 and 57 day patients attended weekly. An assessment of 60 patients from an earlier period does not suggest that the main problems are 'social', but that they have severe psychiatric problems; depressive, paranoid, delirious and manic in nature. Day care integrates with community nursing teams, primary care, social services and district general hospital liaison psychiatry.

Our experience concerning day hospital treatment is not unique. A survey of all districts in the South East Thames Region (Beats *et al*, 1993) suggests that the majority of old age psychiatric services perceive the need for day hospital treatment for primarily clinical reasons.

None of these facts, admittedly, prove that day care is more efficacious or provides higher quality care, neither is there any effective or proven research to suggest the superiority of the alternative to which Dr Ball alludes.

It would seem to us that it is dangerous, without evidence, to propagate these kind of views. In the present climate, where the needs of older patients with psychiatric disorder are increasingly described as being "social", the role of intensive psychiatric and medical assessment and treatment is in danger of being overlooked.

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Sir: Bergmann & Levy bring a wealth of experience of working with the elderly mentally ill in day hospital settings to this debate. They describe the activities of their day hospital echoing much of the published work in this area. The architecture of their service is heavily reliant upon the day hospital setting and so it is unsurprising that they see many of their patients in this arena.

The hegemony of the day hospital is largely the result of historical processes. The welcome development of services for the elderly world-wide has not been matched by a similar growth in innovative thinking about models of service delivery or clear assessments of these models. This has led one set of investigators to conclude "various kinds of day care are available although their purposes are not always clear to clients or to service planners" (Wimo *et al*, 1993). It remains unclear under which particular set of circumstances a day hospital offers the best service to this group of patients or when an alternative approach may be of more value. Identifying these circumstances (e.g. particular patient groups, resources available for non-attenders, local social service arrangements and so forth) in a systematic way will begin to clarify this issue. It is unlikely that a single service paradigm will serve all needs and the balance of individual services will depend upon the local needs taking into account some of these variables.

I am unsure in what sense the views propagated in the original article (Ball, 1993) can be said to be dangerous. We share a common purpose in developing efficient, user-friendly and cost-effective services for our patients. As Bergmann & Levy suggest, there is little hard evidence to guide us in our choices. Developing services to work within the fabric of the patient's normal life represents a logical step in the progression from the "distant and relatively remote" units of the past.

It is a misrepresentation of my views to suggest that patients with mental health problems only have 'social' problems. While the social needs of this group have in the past not been accorded due weight (Murphy, 1992), the importance of psychiatric assessment within the multidisciplinary team framework cannot be understated. Only by working across the artificially imposed medical/social divide can truly rounded management plans be developed.

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Mental Health Review Tribunals in Bradford

Sir: The issue of outcome following Mental Health Review Tribunals (MHRTs) has been the subject of recent studies (Wilkinson & Sharpe, 1993; Saad & Sashidharan, 1992) but the period from initial application to the hearing itself has received scant attention. We would like to report our study in Bradford. All MHRT applications for sections 2 and 3 from January 1986 to July 1992 were identified. A central register provided data on the fate of applications. Information regarding outcome after successful appeal was extracted from the case-notes and a deliberate self-harm register.

Of 682 patients detained under section 2, 86 (13%) appealed. This resulted in 70 tribunal hearings. Thirteen patients were discharged by the tribunal from compulsory detention. Within three months, two of these patients deliberately self-poisoned and attended hospital, and six patients required readmission (two compulsorily). Of the 214 patients detained under section 3, 44 (21%) appealed, leading to 25 tribunals. Five patients had their appeal upheld, and none of these were recorded as being readmitted or carrying out acts of self- harm within the follow-up period.

The proportion of patients who appealed is broadly comparable to other studies (Wilkinson & Sharpe, 1993; Saad & Sashidharan, 1992). We found two reasons for failure to proceed to a tribunal hearing after application: withdrawal of application by the patient (four patients on section 2, and two patients on section 3) and discharge from the section prior to the tribunal (12 patients on section 2, 17 patients on section 3). The median time from application to hearing was six days (range 3–8) for section 2, and 47 days (range 22–112) for section 3.

The lengthy delay between application and hearing in section 3 appeals surprised us and may well be linked with the high rate of discharge by the Registered Medical Officer before the hearing can take place. Further studies are needed to determine whether this is true of the situation nationwide. If so, re-evaluation of procedures should be undertaken.

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Research by trainees

Sir: Katona & Robertson (*Psychiatric Bulletin*, 1993, **17**, 27–29) show that the possession of any publication is associated with shortlisting for a senior registrar interview and advise trainees to "publish . . . or be damned". However, many trainees who express an interest in research are actively discouraged, have difficulty finding the time or do not have the appropriate training. (CTC, 1991). Training in particular improves trainees' research performance (Lewis, 1991).

We performed a questionnaire census of psychiatric trainees in the West of Scotland to identify their current research activities and their perceived training needs; 48 replied (87%). Respondents had been working in psychiatry for a median of 34 months. Seventy-five per cent had sat Part 1 MRCPsych, 14 (29%) were on training schemes with a research tutor and seven (15%) with a designated research post. Twenty-two (46%) recalled undergraduate teaching in research methods, while 17 (35%) had attended post-graduate research lectures, 13 (27%) had attended local research meetings, and two had attended a formal research course. Twenty-two (46%) reported informal teaching from consultants. Forty-seven (98%) felt that further training would be useful, preferring active teaching methods. Thirty-one (65%) had attempted research projects. Twenty-six (84%) had experienced difficulties, the most common problem (24 doctors) being finding sufficient time at work.

The most important influence on taking part in research was interest in a clinical topic followed by worry about future promotion. The most important factor influencing choice of project was having a clear research design. The type of research preferred as a next project was clinical research.

The response rate shows this to be an important topic for psychiatric trainees. With less than half of our respondents having received any training in research methods and 98% feeling they required further teaching, there is clearly a need for structured teaching in this area. Despite this, the majority were taking part in research although most had experienced problems. It has been pointed out that trainees have little time for research as they must acquire clinical skills and pass examinations as well as fulfilling their service requirements. Our results show that most psychiatric trainees are keen to participate in research and, contrary to findings in other specialities (Gaylard & Lamberty, 1989), do so because of an interest in their work. However, they feel inadequately trained and unsupported in their efforts to receive supervision and time to perform their research. Addressing these issues would improve the likelihood of psychiatric trainees completing good quality research projects.

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