and the practice reverted to a 'shifted out-patient model'.

At present we liaise regularly with seven practices in two health centres in south-west Edinburgh using a range of Mitchell's models. In order to allow us to offer a liaison service to *all* GPs in south-west Edinburgh, we have devised a new model – a negotiated, focused, time-limited model. Each practice in the sector, irrespective of size, is being offered in turn a six month service of one session per fortnight. The task is negotiated at the outset, the time commitment on both sides agreed and the duration of service spelled out. The task will probably vary from practice to practice but may well turn out to be one of those described by Mitchell. However we expect the new model also to throw up new tasks. The first new practice has asked us to review a cohort of 'regular surgery attenders' to screen them for treatable psychiatric pathology and help devise management plans. The second practice is discussing benzodiazepine prescription and withdrawal.

We hope that this new model will allow us to work more closely with smaller practices and single handed GPs in the sector. But a spin-off will be the stimulation resulting from our attempts to tackle the unusual variety of new tasks set for us.

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Patient administration systems

DEAR SIRS

I have recently become aware of a patient administration system which is widely used in general practice and distributed free of charge or against a small leasing fee by a company called 'Medital'. Apparently this system is due to be adopted generally by the NHS for all general practitioners.

Although this system seems to have some advantages, I was very concerned when I checked out items relating to psychotherapy where I found rather exotic forms of therapy represented on it, such as five different types of aversion therapy, an item called 'provocative therapy', another item called 'daily-living psychotherapy', etc. Some of the items were more sensible, but I became concerned principally with respect to two issues:

(a) It is well known that such a computer system will both educate and structure the thinking of its users. I would hate to think about my GP colleagues as experts in five different versions of aversion therapy
(b) I would have hoped that with increased computerisation the NHS management would also worry about interfaces between GPs' patient administration systems and the specialist patient administration systems. Ideally such an interface should exist and allow for direct transfer of referral letters by way of fax machines. I would further find it difficult to take a referral from a GP for 'provocative therapy'.*

For me, the need for a clear line from the College on patient administration systems, which would provide a solid basis for the negotiation of a sensible interface with the GPs' patient administration system, is obvious. It would appear that it should be a priority of the College to develop guidelines for such a system, as a good patient administration system could eventually provide information which can radically change the planning of services in the future.

Psychiatrists in the district of Liverpool have adopted a statement of 'user requirements for psychiatric and ECT patients' which would provide a good basis for such a discussion.

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*This statement does not imply a principle criticism of Farrelly & Brandsma's creative and entertaining book on provocative therapy, published in 1974 by Meadow Publications, Cupertino, California.

Mental Health Review Tribunals

DEAR SIRS

As a medical member of a Tribunal for some 16 years, I was saddened to note Dr Heaton-Ward's (*Psychiatric Bulletin*, August 1988) and Dr A. H. D. Hunter's (*Psychiatric Bulletin*, March 1989) comments about the dress of RMOs (presumably only male) when giving evidence at tribunal hearings.

Our lawyer colleagues, including both the President and the patient's representative, sometimes have the tendency to allow the pomposity of the court room to creep into the proceedings, possibly because of their unfamiliarity with the more relaxed atmosphere of a hospital. I consider it the duty of the medical member (hopefully with the help of the lay member) to try and humanise the proceedings. Although I favour a fairly formal style of dress for myself, both when I sit as a member or give evidence

as an RMO, I cannot see that, providing one exercises the ordinary social decencies, what difference it makes how one is attired, tie or no tie, pin stripe suit or jeans.

Within the limits of recognition of the seriousness of the situation in which the civil liberty of a person is at stake, and the maintenance of a disciplined structure, allowing each party adequately to state his or her case, I would favour from my two vantage points as informal procedure as possible. The more the President – who must set the tone of the proceedings – can reassure the patient and his or her relatives that the prime function of the Tribunal is to safeguard the welfare of the patient (and of course other persons) and that nobody is "on trial", the better it will be for all concerned. What one wears on these occasions is, I submit, a matter of supreme irrelevance.

Despite Dr Heaton-Ward's criticisms of RMOs who find difficulty in attending hearings because of pre-arranged out-patient or other appointments, as a busy RMO myself, I have great sympathy with them and it seems only reasonable for the Tribunal to allow a deputy to give evidence or require a relatively brief attendance. I do agree with Dr Hunter that the College should do all in its power to encourage a high standard of reporting to tribunals by RMOs, and I think that this would be best achieved in the long run by making attendance, and perhaps giving evidence at Tribunals, part of a junior doctor's training. What I find truly embarrassing as a medical member is to hear a RMO give evidence when he or she has not made an adequate examination of the patient.

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Treatment of psychotic patients in prison

DEAR SIRS

Dr Herridge reminds us of a situation in the prisons which would be intolerable in a modern psychiatric unit and yet has become accepted as the norm in our prison hospitals (*Psychiatric Bulletin*, April 1989).

The Mental Health Act as an instrument for authorising treatment does not apply in the prisons; not even if the prisoner has been sectioned and is awaiting transfer to hospital. If the Act were to be altered and the provisions extended to cover the treatment of psychotic patients in prison then the Mental Health Act Commission would have to have access to the prison hospital.

Dr Herridge suggests a three day treatment order, presumably equivalent to Section 4; but that would preclude the giving of long-acting medication and also the adequate treatment of the deluded and potentially violent schizophrenic patient. There would have to be at least provision for a 28 day treatment order and the consequence of that would be the right to apply to a Mental Health Tribunal sitting in a large busy prison hospital, which makes the mind boggle.

The right way to proceed is by the use of common law and Section 48. I do common law certificates in our local prisons from time to time. I rely on the doctrine of necessity and the spirit of Section 62(d) of the Mental Health Act.

I would quote Larry Gostin who says, "the doctrine of necessity might be construed more liberally to embrace treatment or restraint administered in the course of an emergency. For example, a tranquilliser injected to calm a patient during a violent episode". I and the prison medical officers have yet to be sued for not acting in good faith.

Section 48 is the right way to proceed. Once the certificates are completed, it can be a phone-in procedure which will be arranged in a few hours with the Home Office. One needs a friendly forensic psychiatrist and an *unsilted* secure unit. The former are arranged by the forensic psychiatrists having weekly sessional commitments to the local prisons and the latter by the profession finally deciding about the nature of the residual psychiatric hospital, and its need to include a well thought out Unit for the treatment of process schizophrenia, perhaps at the supra district level.

Dr Herridge gives us food for thought. The HAS cannot be expected to visit the local doss house or wander around under the arches at night with Dr Weller; but it is surely time that the HAS accepted that their very important contributions would have greater credibility if they incorporated visits to the local prisons before putting pen to paper about the excellence, or otherwise, of local psychiatric services.

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Escapes from Bedlam and lunar phase: failure to confirm the lunacy theory

DEAR SIRS

Despite an extensive confounding literature (Rotton & Kelly, 1985; Campbell & Beets, 1978), belief that