The community care grant is considered by most local authorities to be inadequate. Although a specific grant for the mentally ill will be made available through the regional health authorities, early indications are that funding will be inadequate. As a result more acute beds will be taken up by chronically ill patients who would be better cared for in the community.

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The social state

DEAR SIRS

I thought Campbell and Szmukler's proposal for writing up the social state on every case very interesting (*Psychiatric Bulletin*, January 1993, **17**, 4–7). It would emphasise the importance of social factors in the aetiology and prolongation of illness and would be of practical help at care planning meetings with Social Services. I think, however, their list of points is incomplete as it does not give a heading for responsibilities. Some patients relapse, not because of lack of family or contacts, but because of the pressures put upon them by unavoidable responsibilities such as the care of children, elderly or disabled relatives, and I would suggest they expand their framework to take account of this.

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Who acts as the consultant's nominated deputy?

DEAR SIRS

The article Section 5(2) of the Mental Health Act 1983: Who acts as the consultant's nominated deputy? (*Psychiatric Bulletin*, 1992, **16**, 759–761) highlights problems and uncertainties most junior doctors will face. However, two issues should have been addressed in more detail.

(a) Transfers between hospital sites under Section 5(2) of the Mental Health Act was found to be a problem for example between a peripheral psychiatric unit. While the article was primarily an audit I do feel the opportunity should have been used to resolve the dilemma. As far as I am aware for transfer to another hospital a patient on Section 5(2) would have to be transferred to Section 2 or 3.

(b) Although not categorically stated the audit would seem limited to psychiatric wards. One area that has always created problems is the care of disturbed patients on non-psychiatric wards. It is quite clear from the Mental Health Act that the nominated deputy should be that of the patient's consultant, irrespective of what ward he or she is on. I find that junior doctors in other specialities are extremely hesitant in accepting this responsibility. Perhaps this issue needs to be raised more often in the induction meetings for junior doctors.

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Reply

DEAR SIRS

The comments made by Dr Kazeem are similar to those raised by Fuller (1993). The aim of our study was to explore the variation between health districts in the interpretation of who is most suitable to act as the RMO's nominated deputy. As part of the study, comments about difficulties encountered with the use of section 5 were also invited. A very small proportion of respondents had encountered problems with the transfer of patients between psychiatric hospital sites while detained under section 5. In each case the difficulty had been subsequently resolved. Clearly this is an important issue; however, it is not possible to make a blanket statement to cover all such cases. Inevitably, whether a problem is posed by the transfer (e.g. from a peripheral psychiatric unit to a psychiatric intensive care unit), is dependent upon the structure of local services. If both hospital sites are headed by the same management team as one unit, then the transfer would be within the regulations of the Mental Health Act (1983).

As described in our paper, the study was conducted by sending a seven item questionnaire to the manager responsible for psychiatric services in each district in England and Wales. The study did not undertake to examine the use of section 5(2) by non-psychiatrists. We disagree with Dr Kazeem's statement that it is quite clear who the nominated deputy should be in these cases. Should the nominee of a consultant physician be a junior physician who works for him or her, an on-call junior physician or the on-call consultant physician? Perhaps there is an