Cost of detention of mentally ill patients in prison

Sir: A fortnight before Christmas the phone rang in my office as I was dashing out to do a peripheral out-patient clinic. The probation officer on the line wanted me to make an early assessment on a patient known to our trust who was in custody on remand. As I was starting my annual leave the following week my schedule was busier than usual and I was unable to respond positively. However, as he expressed a serious concern about the deteriorating mental state of this patient in the prison cell, I agreed to cancel the first day of my holidays and visit the prison. My registrar and the nurse in charge made time to accompany me to make a joint assessment.

To my utter surprise an official from the prison telephoned to cancel my visit as they did not have funds to pay the statutory fee for the visiting consultant. We were informed they would try to get an adjournment of hearing for four weeks in the hope that they would get adequate funds to pay the consultant. I should point out that the fee payable is not dissimilar to the domiciliary consultation fee. We all know how much it costs in terms of revenue and emotional pain for a mentally ill patient to be detained in a prison cell. There may well be a logic behind all this but I must admit that I cannot see it. It is ironical that following the Reed report and recommendations to implement court diversion schemes, the hospital trusts and the clinicians are at pains to avoid any delay in assessment of prisoners and transfer as appropriate for hospital treatment. We are coming across a dilemma of cash crisis and bad judgement of priorities within the health care of the prison system.

GILBERT ANDREWS, *Heathlands Mental Health Trust, Ridgewood Centre, Old Bisley Road, Frimley, Camberley GU16 5QE*

Harmful euphemisms

Sir: I read with sympathy Dr Robertson's Personal View – community psychiatry: weasel words (*Psychiatric Bulletin*, 1994, **18**, 760–761) and support his conclusions.

Reason and good sense do not seem to help us so I would suggest ridicule might be the appropriate response. I have found robust and ribald comments stops the peddlers of harmful euphemisms such as 'community care' in their tracks and so provoke more constructive responses.

We should have the self-confidence to say things in 'bad taste' in defence of our patients' best interests.

DAVID MARJOT, *85 The Avenue, Sunbury-on-Thames, Middlesex TW16 5HZ*

Supervision registers

The following letter is in response to an inquiry from the President of the College.

Dear Dr Caldicott

I am responding to your inquiry about supervision registers, and in particular, whether psychiatrists who follow the Department of Health's guidelines on supervision registers will be at greater risk of contravening the GMC's guidance on confidentiality.

The GMC was not consulted by the Department before the introduction of these guidelines, and has not therefore considered them formally. This letter therefore reflects the views of the Chairman of the Standards Committee, rather than those of the council as a whole.

The Department's guidelines make clear that responsibility for maintaining the Register (including ensuring that information is held securely) and for making decisions about disclosures rests with the provider unit, and not with individual practitioners, although the consultant in charge of the patient's care should be consulted before any disclosures are made.

The GMC would be unlikely to hold doctors responsible for improper disclosures, where in supplying information they were complying with NHS guidelines and where they had not taken the decision to release the information. Of course, if a psychiatrist's advice to the provider unit is seriously misjudged the GMC could regard the psychiatrist as contributing to an improper disclosure. However the doctors concerned would not be at any greater 'risk' of disciplinary action from the GMC than is currently the case.

You also asked for more general views on the guidelines. The GMC does not usually comment on decisions relating to the management or organisation of the NHS, which are ultimately for government to determine. However, the GMC has a

https://doi.org/10.1192/pb.19.4.262-b Published online by Cambridge University Press

responsibility to ensure that patients' interests are protected and that the trust between doctor and patient is not eroded by patients' fears that information disclosed to doctors will not be treated as confidential.

The Department's guidelines on supervision registers indicate that entries should be treated in the same way as other medical records and should be subject to the same rules of confidentiality. Although this is acceptable in principle, the Department's draft guidance on 'The confidentiality, use and disclosure of personal health information' allows disclosures on the basis of 'implied consent' on too broad a basis to afford patients the confidentiality they have a right to expect. In commenting to the Department on the draft the GMC drew attention to the problems this might bring in sensitive areas such as mental health, and in particular to the implications of the guidance for confidentiality of information held on supervision registers. The same general concerns have also been raised in the GMC's comments on the draft 'Guide to arrangements for inter-agency working for the care and protection of severely mentally ill people'.

FINLAY SCOTT, *Chief Executive and Registrar, General Medical Council, 44 Hallam Street, London W1N 6AE*

Confidential Inquiry into Homicides and Suicides by Mentally Ill People

Applications for post of Director (Part-time)

The Confidential Inquiry was set up by the Royal College of Psychiatrists in January 1992 at the invitation of and funded by the Department of Health. The Inquiry examines cases of mentally ill people who have committed suicide or acts of homicide at a time when they have been receiving psychiatric care. Its objective is to identify factors in the patients' management which may be related to the deaths and to recommend measures designed to reduce such incidents.

Dr Bill Boyd, the current Director, will be retiring later this year and applications are invited for his replacement. The successful applicant will be responsible for continuing the current programme and developing, in agreement with the Steering Committee, the future research policy and programme of the Inquiry. The appointment will be part-time, with a maximum of four sessions per week. The Director may be employed directly by the College or seconded from an academic institution, NHS setting or the private sector.

For further details please contact The Secretary, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (Tel: 0171 235 2351). The closing date for applications is 10 April 1995.

https://doi.org/10.1192/pb.19.4.262-b Published online by Cambridge University Press