dents who are unable to make considered judgements and as a result are vulnerable

(d) maintaining safe nursing practices which are already operational to protect against Hepatitis B.

Patients who are to be counselled should have an advocate to advise them. We feel that social workers are best suited to carry out this role (in practice, this would normally be the hospital social worker). The role of the counsellor contrasts with that of the advocate in that counsellors present the facts neutrally and do not advise.

The patient who consents to HIV test after fully comprehended counselling can be tested without further ado.

When a patient is unable to comprehend and so give valid consent, or when a resident refuses consent, the Health Authority should go to the High Court to make a person under 18 a Ward of Court, or seek a Declaration for someone older. This is thought to be necessary because identifying a patient's seropositivity might seriously compromise his or her quality of life. This predicament is regarded as being of a similar contentious nature to that pertaining when a mentally handicapped woman becomes or may become pregnant, where good medical practice dictates she should undergo termination of pregnancy and/or sterilisation. In this situation a Declaration is required for each case (Dyer, 1987). This conclusion has been supported by the Mental Health Act Commission (1987). It is possible that in the case of HIV infection one Court Declaration will set a precedent which will render further Declarations unnecessary.

Exceptionally the consultant may feel that the situation is too urgent to incur a delay by going to court. In this case the consultant taking responsibility for performing the test should be prepared to justify such action in court (GMC, 1988). The consultant would be advised to discuss the decision with medical colleagues before taking action.

The management of a proven HIV carrier may be problematic. The patient must be informed of the dangers to any partner and as a result may well end the practice of high risk activities. If a partner is unable to make considered judgements or it is considered likely that there will be such a partner, prevention of transmission of HIV becomes a priority.

It is not possible to anticipate every circumstance and make specific recommendations. Section 3 of the Mental Health Act 1983 is not indicated to control a patient's behaviour if she/he is mildly mentally handicapped, where the sectioning will not benefit him/her.

If the partner is able to make considered judgements it *may* be appropriate to inform that partner of the danger in the same way the General Medical Council has given cautious approval to doctors informing spouses (GMC, 1988).

Patients in a mental handicap hospital have as much right to confidentiality as people who live in the community. Those informed would be on a 'need to know' basis, although it could be possible that precautions required to protect other patients from an HIV patient are so unusual or transparent that their significance would be obvious.

Our Mental Handicap Unit Working Party on AIDS and HIV Infection meets regularly to update the policy and monitor the implementation of its recommendations.

PETER HALL

Levesden Hospital
Abbots Langley
Watford, Herts

PAMELA CROSBY
BEATRICE TALWATTE
CHRISTINE LOGAN

Harperbury Hospital
Shenley, Radlett
Herts WD7 9HQ

References

DYER, C. (1987) Consent and the mentally handicapped. *British Medical Journal*, **295**, 257–258.

GMC (1988) *HIV Infection and AIDS: The Ethical Considerations*. London: General Medical Council.

MENTAL HEALTH ACT COMMISSION: Testing for HIV infection in patients subject to detention under the Mental Health Act 1983. Personal Communication (unpublished) 11 December 1987.

The impact of 'Working for Patients' on psychiatric services

DEAR SIRS

The publication last year of the Government's proposals for the National Health Service and Community Services in *Working for Patients* and *Caring for People* augurs many changes to the provision of care for acute and chronic patients (Department of Health, January and November 1989). The Royal Colleges have responded to the first of these White Papers with some reservations and suggestions for safeguards, but the exact implications for services are unknown and without adequate widespread clinical trials (Conference of Medical Royal Colleges, 1989).

In an attempt to assess the future trends of general practitioner (GP) referrals to a Sub-Regional Alcohol Unit I circulated a questionnaire to 100 consecutive Merseyside GPs who had referred patients to the Lakeside and Windsor Clinics for the combined outpatient and in-patient alcohol assessment and treatment services. The purpose of the questionnaire was explained as a feasibility study into the proposals contained in *Working for Patients*. Eighty per cent of GPs responded using the pre-paid envelope.

GPs were asked whether, if they had a fixed budget to allocate for the care of their practice population, they would continue to refer patients with an alcohol problem to our services. Seventy-nine per cent of GPs (63/80) replied that they would continue to refer to these services, but if then given the choice between referring specifically to out-patient or in-patient services, or both, there was a further change in their behaviour. The proportion of GPs who would continue to use both in-patient and out-patient services fell to 51% (41/80). Twenty-five per cent of GPs (20/80) would prefer to use out-patient and day-hospital services only.

Nineteen per cent of GPs (15/80) said that, given a limited budget, they would no longer use the alcohol services. Of these GPs who said they would no longer refer alcohol patients: 20% (3/15) said they would prefer to use alternative health services for these patients; 20% (3/15) said they would prefer to manage the patients and any required drug treatment themselves; one practitioner declined to comment; but the clear majority (53% or 8/15) said they would prefer to use their cash-limited budget on other patients altogether.

There are methodological problems with this kind of postal survey; for instance, the views of GPs who currently do not refer to our services are unknown, and there are inherent assumptions about the nature of limited budgets and exactly how the contracts for care between primary care and hospital services will be arranged and paid for. The questions are necessarily generalised for not all GPs will be given a practice budget and not all local hospitals will become self-governing. However, the survey does indicate a trend that may form the shape of future health care provision. Taking a business-like point of view, as we are urged to do, a 19% fall in referrals (and hence turnover) from GPs who currently use the service (established customers) cannot be ignored. If GPs who do refer are allowed to specify what form of care they want then there would be a further decrease in the primary care uptake of in-patient alcohol services.

A limited budget is obviously going to be a crucial determining factor in referral behaviour, and much must depend upon the exact size of the budget. If there is a surplus in the budget then presumably there will be less pressure to discriminate between treatments and patients. The White Paper suggests that for the internal market to work though there must be limits to this budget. The Department of Health has proposed an annual practice budget of £600,000–700,000 for about 11,000 patients. This survey suggests that GPs may discriminate between patients as far as the use of their budget is concerned. This has implications for alcohol services and patients with alcohol problems. Whether these implications include an improvement in the quality and delivery of care to these patients is doubtful.

If there is a change in clinical practice towards patients with alcohol problems, then logically there must be changes in clinical practice towards other diagnostic groups. The extent, nature and consequences of these important changes are currently unknown.

BENJAMIN HUGH GREEN
Broadgreen and Park Hospitals
Liverpool

Acknowledgement

I would like to thank my secretary at the Windsor Clinic, Sue Brotherstone, for her kind help in administering the survey.

References

DEPARTMENT OF HEALTH (1989) *Caring for People*. London: HMSO.
— (1989) *Working for Patients*. London: HMSO.
CONFERENCE OF MEDICAL ROYAL COLLEGES (1989) *Building on the White Paper. Some Suggestions and Safeguards*. Royal College of Physicians of London.

Family therapy – the need for research

DEAR SIRS

Despite the initial resistance in turning our attention from individual to systems therapy, the family therapy movement has grown rapidly over the years. Now numerous well established centres exist on both sides of the Atlantic and teaching and practice of the different family therapy models is widespread. But while there has been an enormous increase in the number of studies in the field of family therapy outcome (Gurman & Kniskern, 1978), there is a continuing need for more. Questions that a therapist in the field of family therapy may ask at some point during his/her training are:

(a) What school of family therapy should I gain experience in? Some models are favoured by family therapists with a particular personality. However, as clinicians we should be asking questions such as "Which model of family therapy is the most efficient and most applicable to the type of work that we are engaged in?" Unfortunately there is a lack of research evidence to decide on an answer to this question. Perhaps it is wise to experience as many as possible before concentrating on one specific approach/model. However, there is evidence that structural family therapy should be considered a family therapy treatment of choice for childhood psychosomatic conditions such as anorexia and others (Minuchin *et al*, 1975) and in the treatment of drug addiction (Stanton, 1978). Properly orientated