entity in general rather than for the individual patient with the illness, e.g. 'the prognosis of schizophrenia depends on . . .' rather than 'the good prognostic features in this patient are . . .'

There are a number of elements which determine the prognosis and which you might bring in. You will often find a mixture of *good* and *bad* prognostic features which you will need to balance up in arriving at your final judgement.

You might consider the following:

(a) Known prognostic features of the illness *as applied to this particular patient*, e.g. affective 'colouring' in a schizophrenic illness, acute onset, etc.
(b) The course of the illness—if it is already chronic it is likely to remain so.
(c) Response to treatment in the past.
(d) Co-operation with treatment in the past and now.
(e) Premorbid adjustment.
(f) Social supports and influences.
(g) Motivation to improve.
(h) The availability of special treatment facilities.

It may be helpful to divide the prognosis into the *short term* and *long term*, e.g. the patient may have a good prognosis for recovery from the current episode but be at high risk for relapse in the future.

Staff communication

DEAR SIR

Having read the account of the staff support system at Hill End Adolescent Unit (*Bulletin*, July 1982, **6**, 117-19) I very much doubt whether the desired open communication can be fostered in such a culture. Staff meetings in which the use of first names is compulsory, in which statements are prohibited which are not 'I' statements, and in which there are rules which forbid conversation about absent colleagues and patients, strike me as being every bit as defensive, restricted in communication, and tyrannical as the hierarchical system which the authors purport to eschew.

The danger of such groups is that the members are forced into a pattern of pseudo-open communication in order to conform to rigid group norms; thus more is avoided than is dealt with, tension is greater, and there are repercussions elsewhere in the system.

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Psychiatric experts and expertise—will the real expert please stand up?

DEAR SIR

The article by the barrister, Diana Brahams, on 'Psychiatric testimony—Who can give it and when?' (*Bulletin*, July 1982, **6**, 121–22) raises a number of interesting points as to who is best qualified to give evidence on problems of mental and behavioural abnormality.

In the case cited by Mrs Brahams (Mackenny and Pinfold) I would accept that the qualifications of the psychologist (who was not allowed by the trial judge to give evidence) could be called into question, but I wonder how the matter might have been resolved if the psychologist involved had been a properly trained clinical psychologist—employed by the National Health Service—who had experience in diagnosis and treatment of mental disorder, and who was conversant with preparing reports for solicitors as well as in giving expert evidence in courts, be they at Magistrate, County or higher courts.

My own experience in legal matters indicates that clinical psychologists not only provide reports for solicitors, but that in many instances solicitors (as well as barristers) specifically request a psychologist's report in preference to or, in conjunction with a medical or psychiatric report. Moreover, examples of cases where psychologists are requested to attend Court to give evidence include Compensation (brain damage, psychological effects of personal injury); Matrimonial (access, custody, care proceedings); Juvenile and Adult Crime (burglary, damage to property, murder, rape, theft), not to mention acting in an advisory capacity to the legal profession.

I can recall an occasion (the first time I gave evidence) when the 'other side' in a compensation case objected to my report—and presumably me as well—being granted 'expert' status. The learned judge, after listening to counsel's objections, took a few moments before giving his decision on my report, namely—'Oh nonsense, put it with all the rest!' (i.e. the medical reports). Despite my nod of approval at the time, I later realized that His Lordship had poured equal scorn on both the so called medical and psychological expertise. A fuller account of this incident has been reported elsewhere (Kaufman, 1980).

A few months ago I was asked by another judge if I was qualified to give an opinion on a man's state of mind concerning whether or not he was suffering from an 'abnormality of mind' at the time he took money belonging to his firm, because, after all, I was 'not a psychiatrist'. My reply was that not only did I think I was qualified to offer my opinion, but that in my experience as well as that of many of my colleagues, we are often referred cases (by psychiatrists) for our diagnostic assistance. I also pointed out that in one area of clinical psychology specialization, the task is one of deciding if an abnormality in behaviour or deterioration in intellectual function is due to an organic as opposed to a non-organic cause and, in some instances, to help pinpoint the site of the lesion in diagnoses of cerebral deficit.

These explanations appeared to satisfy the learned judge and no more was said of my qualifications to give evidence as a clinical psychologist or, to give evidence on the matters in question, even by the very thorough opposing barrister appearing for the prosecution.

I can cite other instances where I have been asked to