Sometimes mentally disordered people are refused admission to a psychiatric unit or abruptly discharged because of a violent act or the suggestion of a history of violence. This certainly seemed to happen in the case of Christopher Clunis; the more disturbed he became the less effective his care became. Surely there should be research about how many patients are refused admission or abruptly discharged and what subsequently happens to them.

There seem to be problems about confidentiality when carers contact psychiatric services with their concerns over patients who are becoming violent or aggressive. There is a need for guidelines about how such calls from carers are handled by psychiatric units and those guidelines should be subject to clinical audit. Sometimes it seems that concerned carers are simply ignored and no action seems to be taken.

There seems to be hardly any research about the safety of carers. Life-threatening assault may be rare but frightening assaults and aggressive behaviour are very common. It can disrupt family life, leading to young family members staying away because of safety fears and chronic disruption of carers' sleep.

There seems to be a real problem with police liaison and patients sometimes fall between the police and the psychiatric services, neither willing to step in. There need to be guidelines about what information is passed onto the police.

I hope your readers find these thoughts of some help as they continue to try and make community care work; if it is to work carers need to be listened to.

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Protecting vulnerable elderly people from risk

Sir: Morris & Anderson's description and discussion of the use of the Mental Health Act in the elderly is a welcome presentation of the relevance of this provision in good psychiatric care in old age (*Psychiatric Bulletin*, August 1994, **18**, 459–461).

We would strongly endorse their view of the value of detaining patients with severe dementia who are at significant risk. We pursue an active policy of intervention when the community mental health team, in conjunction with the family, other caring agencies and the primary health care team, believe that the risks have become too great for an individual to remain at home in reasonable safety. The care programme approach has been helpful in formalising the process of consultation and decision making (Broughton & Divall, 1994). The majority of patients brought into hospital in this way rapidly settle, cease to express the desire to return home, and can often be discharged to appropriate residential or nursing home accommodation.

We concur with their view that use of the Mental Health Act makes explicit the lack of competence on the part of the patient to make decisions about their care, and by so doing, gives them and their relatives proper legal safeguards.

We have argued similarly that guardianship is also an important power, allowing clarity about decision making for the incompetent dementing elderly, where total co-operation may be absent, usually through lack of insight and determinedly independent pre-morbid character. In the Bath Health District area of Avon County (approximate population over 65 of 22,000), we have been instituting about ten new guardianship applications per year for the last three years. In research, which is currently submitted for publication, we have demonstrated that the applications have achieved the aims they were intended to meet, and the use of guardianship has been well understood, and thought helpful by relatives of the patients and others concerned in their care.

We therefore believe that, even without amendment of the present legislation, guardianship does offer a way to protect vulnerable elderly people from risk, and safeguards their legal rights. We would encourage others to consider making more extensive use of this provision.

BROUGHTON, M. & DIVALL, P. (1994) The care programme approach: the experience in Bath. *Psychiatric Bulletin*, **18**, 77–79.

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Informed consent?

Sir: A. White (*Psychiatric Bulletin*, August 1994, **18**, 507) questions the acceptability of oral consent for ECT obtained from a man whose delusional system prevented him from signing a form he believed Satan had signed. There is no legal requirement for informed consent to be recorded in writing; oral consent is as valid but may result in problems should a dispute arise needing evidence. Hence written consent is the norm for many procedures.

A signed consent form does not necessarily mean informed consent has been given and may therefore give a false sense of security. To be valid, the patient needs to have understood, in broad terms, the nature, purpose, principal benefits, unwanted effects and alternatives to