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help was the solicitor instructed by my trust to defend me in court.

Having read the paper by Dewar *et al*, I feel I would have benefited from some training for the consequences or the organisational procedures following suicide. I feel I should have had a mentor or a similar senior person to open up to.

Senior house officers are the most vulnerable doctors, owing to their relative inexperience and the fact that it is often the first time they come across suicide. There should be a better support network when something on these lines occurs.

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development of community care. They are not now, and never were, intended to be a means by which psychiatry could control antisocial behaviour.

The efficacy of CTOs has not been established, but having practised with them and without them we feel that they have an important part to play in good clinical care. We agree with Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) and wish to move the debate away from the issue of prevention of violence towards the provision of humane, community-based care.

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would seem to us that history can inform the usefulness of the CTO approach.

We strongly concur with Burns (*Psychiatric Bulletin*, November 1999, **23**, 647–648) that these orders are not about bad behaviour, but about therapy and treatment for people with limited insight who have a right to such treatment. The challenge to psychiatry lies in educating the public that untoward behaviour will always occur, even with CTOs in place. The problem with the language of 'social control' is that it makes it very easy to be a bad Samaritan.

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Experience of community treatment orders

Sir: We wish to reply to Moncrieff & Smyth's paper on community treatment orders (CTOs) (*Psychiatric Bulletin*, November 1999, **23**, 644–646). We write as British psychiatrists working in Melbourne where CTOs have been in use since 1987. In our service 161 adults (18–65 years) out of a total catchment area population of 225 000 are subject to a CTO. CTOs are regarded as part of good clinical facilitating treatment in the least restrictive environment many lasting for only a few months after hospital admission.

The CTO enables the clinician to insist on clinic attendance and the patient's acceptance of oral or intra-muscular medication. If the patient refuses to comply then the CTO may be revoked and the patient admitted to hospital, usually for a very brief period. This ultimate sanction is rarely required. The CTO is only one part of a comprehensive biopsychosocial care plan. An order may alter the dynamics of care, but the clinician–patient relationship is usually remarkably well preserved. In our clinical experience, CTOs are most helpful if some sort of therapeutic alliance has been established. This alliance can be continually developed and improved particularly by psycho-education sessions.

We dispute Moncrieff & Smyth's surprising statement that CTOs would increase the amount of medication administered and, therefore, side-effects. In our experience, doses as low as 20 mg of flupenthixol depot monthly are sufficient to spare an insightful patient the indignity of regular compulsory admissions to hospital with all the extra medication and restrictions that these inevitably entail. A prolonged symptom-free period may demonstrate the benefits of psychiatric care to a person with a recurrent psychotic illness.

The introduction of CTOs in Victoria was an integral part of the state-wide

Sir: The issue of community treatment orders (CTOs) continues to create difference within the College, but Moncrieff & Smyth (*Psychiatric Bulletin*, November 1999, **23**, 644–646) have added nothing new to the debate. Rather, by drawing the issue away from the practical question of how to help a small group of vulnerable people, towards vaguely defined issues of social control, they may be doing psychiatry a disservice. They have been selective in their references, avoiding the many articles evaluating CTOs in other countries, for example the USA and Australia. Most of their arguments are as relevant to any kind of compulsory treatment as to that specifically located in the community.

The notion, furthermore, that it was "concern for patient rights that underscored the move away from the asylums" is only partially true. There were certainly concerns about institutionalisation, recognised by numerous hospital inquiries, but the impacts of modern medication and of the resource implications of an ageing real estate were just as powerful. The rising demand for medium secure unit beds reflects the way in which the asylums are returning, in another form, while the rising level of Mental Health Act sections reflects the distress of a number of chaotic, relapsing individuals for whom current community provision is simply inadequate.

One of us recalls a rather angry argument in the 1970s, about the introduction of car seat-belts, in which a senior physician suggested that it was a gross infringement of personal rights to be ordered to wear a belt. Yet the impact of a seat-belt law, in terms of reduced head injury and general morbidity and reduced mortality, has been immense. With the appropriate legal safeguards, the use of enhanced tribunals or other legal agencies to monitor community treatment, and reversion of psychiatrists to their proper role (as therapists rather than turnkeys), it

Survey of supervised discharge of mentally ill people

Sir: A postal survey was conducted (April 1996–June 1997) to determine the attitudes of consultant psychiatrists working with adult, adolescent or psychogeriatric patients in the Wales Region towards the new legal powers.

After 12 weeks there had been a 31% (107/300) response rate. Only six patients in total were placed on supervised discharge by three of the 107 respondents. Twenty-eight of the 107 respondents stated that they had considered using the new legislation regarding supervised discharge, although 53 had reservations.

Three aspects caused concern when the respondents were asked about the factors that influenced the decision to recommend supervised discharge. Supervised discharge would generate an increased workload, for which resources are not available (5/107); there was no sanction on the patient if he or she did not comply (30/107); and, properly resourced community care could be used instead of supervised discharge (27/107). Several respondents commented that the legislation was insufficient in its powers and that the legislation would not be appropriate for patients lacking insight.

Respondents felt that confusion existed while processing the paperwork and the forms need to be simplified and clarified in order to avoid unnecessary time consumption.

Although the Act introduces a new somewhat convoluted system of procedures for supervised aftercare, and has serious implications for both human rights and the relationship between care professionals and their service users, it is difficult to see it as an improvement on the possibilities for intervention under



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current legislation. The fact is that there are no new powers and these patients still have to deteriorate and then be re-admitted compulsorily before they can receive the treatment they need.

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Is this informed consent?

Sir: The *Code of Practice* (Department of Health & Welsh Office, 1999) sets out in detail the basic principles governing consent. It is clear from this that in order to understand the nature, purpose and likely effects of a treatment patients require some awareness of their diagnosis. The *Patient's Charter for Mental Health Services* (Department of Health, 1997) states that patients can expect "to be able to ask for an explanation of your diagnosis in plain language and to ask for more information if you do not understand". This raises the question as to how much psychiatric patients know about their formally allocated diagnoses, with the implication this has for consent issues.

We conducted a questionnaire survey of out-patient and day hospital attendees, under regular psychiatric follow-up, with a view to considering this issue locally. An impressive knowledge of diagnosis was demonstrated by those patients suffering schizophrenia (72%, $n=18$), bipolar affective disorder (79%, $n=14$) and depressive disorders (89%, $n=27$). However, those with a primary diagnosis of personality disorder or substance misuse problems demonstrated considerably less awareness of this in their responses (with only 25%, $n=24$ and 42%, $n=12$, respectively). Whether this means that they have never been informed of the diagnosis, did not understand the explanation, are unable to recall it or choose to disregard it is unclear. However, if there is genuine ignorance among this group as to what it is that is being treated, then careful thought must be given to matters of consent. Are the patients consenting to the same thing as the treating psychiatrist imagines? Can you have informed consent in the absence of diagnostic awareness?

DEPARTMENT OF HEALTH (1997) *The Patient's Charter for Mental Health Services*. London: Department of Health.

— & WELSH OFFICE (1999) *Code of Practice*. London: HMSO.

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Calman reforms

Sir: I was interested to read Cavanagh & Haut's survey of higher psychiatric trainees to assess satisfaction with changes brought about by the Calman reforms (*Psychiatric Bulletin*, August 1999, **23**, 493–496). The survey uncovered dissatisfaction with the new specialist registrar (SpR) grade, which took the place of the senior registrar (SR) grade in 1996. Little objective evidence was found of differences between the two grades. However, one such difference is that of pay scales. The abolition of the registrar grade has meant that trainees remain on the senior house officer pay scale until they are appointed as SpRs. In addition to this, the SpR scale starts at £23 300, compared with £26 840 on the SR scale, and only reaches the higher figure at the fourth point of the SpR scale. Therefore, rather than the reforms putting "training at the top of the agenda" (Smith, 1994), they could be more cynically viewed as a cost-cutting exercise. The authors found that more flexibility for time in higher training and restoring the SR title would help to improve morale. Surely restoring SR pay would further contribute to such an improvement.

SMITH, R. (1994) Challenging doctors: an interview with England's chief medical officer. *British Medical Journal*, **308**, 1221–1224.

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Use of Section 62 in clinical practice

Sir: Recent articles concerning the use of the Mental Health Act have tended to focus on the use of commonly used parts of the Act such as Sections 2 and 3 (Turner *et al*, *Psychiatric Bulletin*, October 1999, **23**, 578–581). We chose instead to survey the use of Section 62 (urgent treatment) across three psychiatric units in Bristol for the years 1990–1997.

During the study period 60 patients received urgent treatment. The frequency of use varied across the units as follows: Unit A, 14 cases; Unit B, eight cases; Unit C, 38 cases. On all occasions the urgent treatment used was electroconvulsive therapy (ECT).

We found that in 18% of cases Section 62 was applied more than once during a course of ECT seemingly due to delays in gaining a second opinion.

The *Code of Practice* (Department of Health & Welsh Office, 1999), places the responsibility for devising a form for

Section 62 (as well as monitoring its use), upon the managers of individual trusts. Although (different) forms were available on all three units, the subsequent filing of documentation varied between sites. Only one manager kept both a record detailing the use of the section as well as a copy of the form separate from the notes.

As far as we are aware this is the only published survey concerning the use of Section 62. The variation in use of Section 62 across units along with its occasional multiple use would seem to indicate the need for a standardised form as well as a more detailed review in the Mental Health Act Commission's biennial report to Parliament.

DEPARTMENT OF HEALTH & WELSH OFFICE (1999) *Code of Practice. Mental Health Act 1983*. London: HMSO.

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Recommended reading for trainees

Sir: I read with pleasure Henry Rollin's *Psychiatry at 2000* (*Psychiatric Bulletin*, January 2000, **24**, 11–15). I shall recommend it to trainees.

To add a footnote, I have the *Annual Report for the Cumberland and Westmorland Lunatic Asylum for 1892*, written by the Medical Superintendent, Dr J. A. Campbell. That year the Asylum had 580 inmates and a total of 52 attendants.

Dr Campbell includes a summary of the Asylum's work between 1882 and 1892. There had been 1537 admissions of whom 679 were discharged recovered and 503 (33%) had died. There were two suicides and three 'fatal casualties'. Most of the deaths (29%) were due to physical causes. One hundred and eighty-eight had cerebral or spinal disease, 113 had 'senile exhaustion', 77 were diagnosed with general paralysis of the insane and 62 died of tuberculosis.

These figures suggest that the asylums unintentionally provided chronic or terminal care for non-mental disorders. The social value of this activity deserves remembrance in accounts of 19th century mental health provision. If these deaths are excluded then the average discharge rate was 62% in spite of the lack of effective treatments.

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