required high dose medication and that where it was prescribed the reasons were clearly given and the progress closely monitored.

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Treatment in secure accommodation with emergency medication (Children Act, 1989)

DEAR SIRS

A ruling to treat with emergency medications in secure conditions under Section 8 (Specific Issue Orders) of the new Children Act, 1989 was recently requested of the High Court on behalf of three young patients. Concern had arisen that use of emergency psychotropic medication for minors was not covered by this Act although parental permission had been obtained and the patients were each detained under Section 25 of the Act on a Secure Accommodation Order.

In the event, the Bench directed that they were 'Gillick incompetent' and did not need to attend Court. Also, doctors had a "duty to treat in accordance with their best clinical judgement" without impediments and that the consent of one parent was sufficient to provide a suitable "flak jacket" allowing appropriate treatments, including emergencies. A Specific Issue Order was unnecessary as the Act was seen to be clear in its intent to provide treatment. Reference was made to test cases of *Re R* and the appeal case of *Re J*, where it was ruled that the Court would not order a doctor to treat a minor contrary to clinical judgement "subject to obtaining any necessary consent" (All England Law Reports, 1992).

This recent ruling, therefore, should provide support to the treatment of disturbed young people in secure settings, when appropriate. Health professionals who avoid using the Mental Health Act for young people, may now feel able to utilise the Children Act, given informed consent by a responsible parent.

As there is little reference to the Mental Health Act or to doctors' "clinical judgement" in this extensive body of law, these might be subjects which could be incorporated in any future revisions, I would suggest.

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Reference

ALL ENGLAND LAW REPORTS, Re J (a Minor), 20 November 1992.

A community treatment order

DEAR SIRS

The Secretary of State for Health's proposals on the care of the mentally ill in the community (*The Guardian*, 4 January 1993) include a suggestion for a community treatment order, a subject that can be traced back to the Mental Health Act 1959. The concept of guardianship, which under the Act gave the guardian wide powers of control, has not been widely taken up because it is unenforceable. Such will be the case with a community treatment order for the same reason.

This hospital is currently evaluating its implementation of the Care Programme Approach (CPA) and it is quickly becoming evident that compulsory treatment in the community is not only difficult to enforce but unacceptable to the patient and to the clinical team. Professor Sims is correct in rejecting the vision of administering injections to patients "on the kitchen table".

This, of course, does not mean that our vulnerable patients should not be closely monitored after discharge from the hospital. The CPA notion of a keyworker system is essentially a good one and often acceptable to the patient. A good relationship between keyworker and patient will ensure that community supervision will not be intrusive to the patient but will, at the same time, ensure adequate support. However, if resources continue to trickle down slowly to these vulnerable patients, whatever legislation is introduced will be yet another attempt at window dressing.

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Appeal from Croatia

DEAR COLLEAGUES

We write to ask for your help. After a year and a half of war in Croatia our hospital is in a difficult situation, with a huge lack of medical supplies.

Our hospital is one of the biggest hospitals in Croatia for adult psychiatry and geriatrics. There are

about 800 chronic psychiatric patients in hospital, mostly schizophrenic. About 200 of them are acutely psychotic and those in remissions also need prolonged pharmacologic treatment.

We currently lack most antipsychotic drugs, some not available now in Croatia, and others too expensive for our limited funds. So, we are short of neuroleptic drugs, antiparkinsonians and benzodiazepines.

In better times we mostly used haloperidol, flufenazine, clozapine, promazine, chlorpromazine, thioridazin, carbamazepine, levamepromazine, buperidine, triheksifenidil, diazepam, nitrazepam, flurazepam, lorazepam.

If you are able to help us in any way we would appreciate it very much.

We hope to hear from you soon.

SANJA MARTIĆ-BIOČINA
JOŠKO VULETIN

Neuropsychiatric Hospital
"Dr Ivan Barbot"
41317 Popovaca
Croatia

The reliability of delivery of interim discharge slips by psychiatric patients

DEAR SIRS

Kerr (1990) expressed doubts about the reliability of the psychiatric patient as a messenger for communication between the hospital and the family doctor. A comprehensive study has been carried out on medical patients comparing the reliability and speed of arrival of interim discharge slips sent by hand and by post (Sandler & Mitchell, 1987). They found that 97% of the slips in both groups arrived, and that 55% of the by hand group arrived within one day. No such work has been carried out on psychiatric patients.

I took 50 consecutive discharges from an acute admission ward. Each acted as his or her own control having a by hand and a by post slip. The slip contained information as to the nature of the admission, follow-up arrangements and the medication on discharge. The doctors' surgeries were contacted by telephone to determine arrival of the slips.

Ninety-eight per cent of the slips sent by post arrived compared with 66% of those sent by hand. Of the 32 pairs, where both arrived, a Wilcoxon Rank Sign test was statistically significant at $P<0.01$. The by post group had a median delivery time of four days compared with one day for the by hand group. There was no significant difference between diagnostic groupings or when Caucasians were compared with Asians.

The posted interim slips therefore arrived more reliably but slower compared with those sent by hand. As the quantity of tablets for a patient to take home gets smaller and the cost of postage rises, I felt it was important to know the reliability of delivery of discharge slips in psychiatric patients. The reluctance to tell the general practitioner of the psychiatric admission may be due to the perceived stigma of mental illness or to lack of insight as part of the illness.

Ideally each patient should have both a by hand and a by post slip (the former ensuring that the latter is written before the patient leaves the hospital). A triplicated pad would allow a record also to be kept in the notes. Where there is only one interim slip this should be posted to ensure reliable delivery. This may lead to practice being changed in some hospitals.

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Junior doctor representation

DEAR SIRS

At the end of the article 'Working for Trainees' (*Psychiatric Bulletin*, February 1993, **17**, 98–99), the authors' state that they are aware of at least one other active organised junior psychiatric trainee group working at a regional level. Such a group has been set up in South West Thames, with very active trainee participation.

The St George's professional scheme comprises four registrar rotations and two central SHO rotations, which together account for approximately 90 trainees. Each hospital on the scheme has its own local representative, and each of the SHO or registrar rotations has an elected representative. There is a chairman who is elected by all members of the rotation, and represents trainees' views at regional level.

The corner-stone of representation is the two-monthly junior doctors' meeting which is attended by all representatives. St George's Hospital also has a local BMA representative, two trainee members of the Royal College Training Committee and a senior registrar representative. These meetings are a means of conveying problems at local level so that they may be discussed and a possible strategy reached. This organisation has been responsible in part for improving the quality of some of the less desirable jobs on each rotation, and as in Liverpool the trainee criticism seems to have been viewed as constructive by the psychiatric tutors.