Correspondence

Home Secretary's comments on the Stone case

Sir: I was dismayed by the Home Secretary's comments on the Stone case on BBC Radio 4 on the 27 October 1998. He told the radio audience that psychiatrists get caught up in the "intellectual" trap of not forcing treatment on antisocial personality disorders by using the feeble excuse that these patients are untreatable. He added that psychiatrists are only likely to act when the individual commits a serious crime, implying perhaps that we should be more proactive and incarcerate the person at the earliest opportunity. He finally declared that if psychiatrists are unable to treat people with these diagnoses, perhaps other disciplines could help, ignoring the existence of multi-disciplinary work in mental health.

This type of populistic reaction to a tragedy is unhelpful. A horrific crime is being portrayed by the Government as a mental health failure, even if the perpetrator was not mentally ill. The "lock them all up" concept is simplistic, unworkable, certainly illegal, and probably undesirable. We should actively reject our increasingly custodial role and the idea that psychiatry is primarily about containing dangerousness, and that therefore dangerousness must be in itself a psychiatric responsibility.

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MHRT medical reports

Sir: Ismail *et al* (*Psychiatric Bulletin*, October 1998, **22**, 615-618) have produced a study of 100 consecutive mental health review tribunal reports in an attempt to discover what proportion satisfy the criteria for detention in accordance with the Mental Health Act 1983. This is an important issue that will aid the tribunal process and, therefore, deserves wider recognition.

However, the authors have themselves been guilty of a small but fundamental error that also plagues many MHRT reports. They state under criterion (c) "Is the mental disorder of such a nature and degree . . .". Of course, the wording of the Act is nature or degree and there is some legal difference between the two. The word 'and' implies that both must be present while 'or' gives rise to a different meaning entirely, that is either nature or degree is sufficient in themselves. Is this distinction important you may ask? Consider the case of depression. How severe must it be before it constitutes a mental illness for the purpose of the Act? All individuals suffer some feelings of depression at some point in their lives but for the majority this is not considered abnormal. The nature of the illness is not what is the issue in this example, it is the degree. That is why they remain separate and to use them mutually is more than just a typographical error, it is not the law.

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CPD: monitoring attendance or measuring performance?

> "Not everything that counts can be counted and not everything that can be counted counts" (Cameron, 1963).

Sir: The only conclusion that one makes looking at the College Continuing Professional Development (CPD) logbook is that a consultant has managed to attend a certain number of meetings covering various CPD models. This does not indicate whether this consultant has or has not continued to develop professionally as the CPD implies. The question that should be addressed is: What value or benefit has the frequent attendance of CPD meetings made to the service and patient's care?

A good proportion of CPD meetings that psychiatrists attend, with the exception of very few international and national conferences, are essentially pharmaceutical mini-breaks, usually in Europe or some exotic place. To attend such meetings, doctors are almost certainly paid by drug companies with an inevitable, subtle or obvious, promotional component for their products, especially the new, expensive, psychotropics.

It is now time to have a look at the current CPD in order to accommodate a system of periodic assessment of doctors. A system that encourages doctors to respect changes and integrate into practice innovations that are shown to enhance patient care. The traditional continuing medical education and professional development, that update doctors' knowledge, should be replaced by a system that ensures 'actual' professional

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development that can be monitored and facilitates team learning and performance enhancement in multi-disciplinary setting (Young, 1996). What is needed is a system that evaluates medical performance rather than doctors' attendance of 'points-generating meetings', which perhaps have more value to those who organise them and to those who collect signatures.

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Transforming mental health legislation

There is an international precedent to the revolutionary change to mental health legislation proposed by Zigmond (*Psychiatric Bulletin*, November 1998, **22**, 657–658). In 1974 in Jamaica there was an Amendment to the 1930 Mental Hospital Act, which has achieved the predicted effect on the medical incapacity act proposed by Zigmond.

The 1974 Amendment provided the foundation for the establishment of community psychiatry in Jamaica (Hickling, 1993, 1994). The Amendment allowed mental health officers to become the agents of therapeutic intervention, replacing the police as the designated officer for the apprehension and removal of the acutely ill patient to a place of treatment. The law Amendment also allowed any medical facility to replace the asylum as the sole place of assessment and treatment of the mentally ill.

This legislative amendment has allowed mentally ill people to be admitted to medical wards in general hospitals and treated under the legislation governing the physically ill. There has been no need for the development of expensive and unwieldy systems of mental health tribunals for the protection of the civil liberties of patients. The 1974 Amendment has encouraged a benevolent and syncretic relationship to develop between mentally ill people, their families, the mental treatment services, the police and the legal system.

In the years since the introduction of the 1974 Amendment, a remarkable system of community mental health care has developed around the island. Admissions to the Mental Hospital have fallen by 80%, and there has also been a reduction on the total number of psychiatric hospital admissions island-wide of nearly 50% (Hickling, 1991, 1994). By 1993 merely 5% of the total psychiatric admissions were by compulsory detention under the statutes of the 1930 Mental Hospital Law.

The openness and the flexibility of the 1974 Amendment has allowed the families of patients to take the legal responsibility for the admission of their mentally ill relative with incapacity in the same way that they would if their relative with incapacity had suffered from a non-psychiatric illness requiring their admission to hospital, but which prevented the patient from personally giving their permission for admission. There have been no negative medico-legal sequelae to these practices in the 25 years of operation of the legislative amendment.

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New drugs and the NHS

Sir: May I applaud the paper by David Taylor (*Psychiatric Bulletin*, November 1998, **22**, 709–710) lamenting the conventional disgruntlement which seems to characterise our approach to new pharmacological remedies. This may reflect a general preference for social/psychotherapeutic strategies, or more sinisterly a willingness to devalue the needs of our patients. Many psychiatrists seem quite content to paralyse the non-verbal communication of people with schizophrenia to save a paltry £1000 per annum (by prescribing a conventional dopamine blocker). Similarly, we seem willing to regard Alzheimer's disease as untreatable, our patients not meriting six further months of good function. Our colleagues treating HIV infection have no qualms in spending £10 000 a year to treat their patients. Neurologists will have to decide whether to spend £10 000 per annum on beta interferon to reduce the relapse rate of multiple sclerosis (Goodkin, 1998). Paediatricians spend £5000 a year on growth hormone to restore growth, gastroenterologists spend £500 a year to prevent gastric bleeding in patients who need NSAIDs, all worthy objectives. However psychiatrists are prepared to accept that a patient with

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