two-stage procedure. We found that this was more manageable, particularly as sustaining interest in the topic over three weeks was difficult. It also allowed us to include both audit and some 'non-conventional' presentations in the programme. It meant more work for one individual (as Sackett's method involves a group discussion resulting in the best evidence to appraise), but as trainees became more familiar with using resources such as the CEBMH the time involved was reduced.

Thus, we have found that this methodology is both stimulating and useful, and believe that it has the potential to deliver better care for our patients. The major difficulties have been overcoming the inertia of changing the old methods by teaching new skills, and often the dearth of quality information to answer our questions! However, we are confident that both will change given time, and from our own experience this change will be for the better.

## References

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *Statement on Approval of Training Schemes for General Professional training for the MRCPsych* (Court of Electors/General Professional Training Committee). London: Royal College of Psychiatrists.

SACKETT, D. L., RICHARDSON, W. S., ROSENBERG, W., *et al.* (1997) *Evidence-Based Medicine. How to Practice and Teach EBM*. Pp. 190–197. London: Churchill-Livingstone.

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## Psychopathic disorder and autistic spectrum disorders

Sir: We write with respect to Council Report CR71 on *Offenders with Personality Disorders* published earlier this year (Royal College of Psychiatrists, 1999) just prior to the release of the Home Office Document *Managing Dangerous People with Severe Personality Disorder; Proposals for Policy Development* (Home Office, 1999). Both documents deal to some degree with the issue of the legal term 'psychopathic disorder' and its relationship to severe personality disorder. In addition the Home Office document introduces a new term 'dangerous severe personality disorder' (DSPD) and seeks to highlight the complexity of this area.

However, there is an important issue that has been overlooked by both documents and has fundamental implications for any future service provision. This is the significant number of individuals detained under the legal category of psychopathic disorder who have autistic spectrum disorders. Some of these individuals have been classified as having personality disorders, usually schizoid, schizotypal or anankastic in type. A number are already in a variety of different secure provisions, some in forensic psychiatric services including special hospitals. This issue was recognised by Coid (1992) in his important survey of individuals held under the category of psychopathic disorder but appears to have been overlooked in these two recent influential documents.

It is likely that the service provision for these individuals will need to be quite different from provision for antisocial or dissocial personality disorders. Autistic spectrum disorders are much more common than previously believed, but there has been little research in the areas of outcome or their long-term management, particularly in forensic settings.

## References

COID, J. W. (1992) DSM–III Diagnosis in criminal psychopaths. *Criminal Behaviour and Mental Health*, **2**, 78–94.

HOME OFFICE (1999) *Managing Dangerous People with Severe Personality Disorder. Proposals for Policy Development*. London: Home Office & Department of Health.

ROYAL COLLEGE OF PSYCHIATRISTS (1999) *Offenders with Personality Disorder*. Council Report CR71. London: Gaskell.

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## Guidelines on the management of imminent violence

Sir: The Royal College of Psychiatrists' *Guidelines for the Management of Imminent Violence* (1998) offer an evidence-based approach to dealing with the problem of violence in psychiatric settings. The guidelines imply that a prototypical violent episode is perpetrated by a patient with psychosis and is therefore manageable using a combination of psychological intervention, containment, restraint and medication.

In Bradford Community NHS Trust there were 1254 reported violent incidents for the year 1996–1997 (further details available from the

author upon request). An audit sampling two months' violent incidents demonstrated that the standardised NHS incident reporting form (IR1) relies on staff entering vital details of the episode as free text. This led to the identification of perpetrators of violent incidents for only 39 of 199 reports. Thirty-seven sets of case notes were recovered. Most of the perpetrators (27/37) had a history of violence documented in the case notes. The majority of perpetrators (20/37) were of informal status. A minority (11/37) of incidents were judged to be precipitated by psychosis or cognitive impairment.

This audit suggests that the College's Guidelines for restraint, seclusion and medication, apply only to a minority of patients who perpetrate violence against co-patients and staff in psychiatric settings. Application of the College's Guidelines may, therefore, have limited value in reducing the frequency of violent episodes. I suggest that, as violent conduct on the part of an informal patient could be viewed as withdrawal of consent to admission, the Mental Health Act may act as a useful template for decision-making following a violent incident. The College's Guidelines would then apply to those patients detained under the Mental Health Act. Where are the guidelines on how to manage the others?

## Reference

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Management of Imminent Violence. Clinical Practice Guidelines to Support Mental Health Services.* Occasional Paper OP41. London: Gaskell.

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## Psychotherapy provision within the NHS

Sir: The Bulletin recently published two articles pertinent to psychotherapy provision within the NHS (*Psychiatric Bulletin*, July 1999, **23**, 390–393 and 445–447). Both clearly highlight the important and vital role for consultant psychotherapists within the provision of NHS mental health services and the difficulties in persuading purchasers to fund such posts.

We wish to draw attention to a potential situation which may, in the long-term, make matters more complicated.

There has been an expansion in the numbers of consultant psychiatrists and currently there are many unfilled posts in England and Wales (perhaps in excess of 400). By contrast psychotherapy has had zero growth in numbers and there are no unfilled posts. Perhaps as a result of these facts there is concern among some specialist and senior registrars in psychotherapy that there may not be a consultant post for them when they have finished their training.

Many specialist and senior registrars undertake dual training in order to gain the Certificate of Completion of Specialist Training (CCST) in both general psychiatry and psychotherapy. Given the shortage of general psychiatrists, purchasers may find the creation of split posts preferable to the creation or pure psychotherapy posts. With the current demands on general psychiatrists those appointed to dual posts are likely to find themselves pressured into spending increasing amounts of time responding to acute problems to the detriment of their ability to practice psychotherapy in an effective manner. In addition employing psychotherapists with single CCSTs in psychotherapy may become regarded by trusts as a less attractive option. Consequently these individuals may have more difficulty in finding a consultant post.

If these changes do come to pass, the future of psychotherapy as a stand alone speciality within the NHS would be severely undermined to the serious detriment of both training and service provision.

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## GPs views on discharge summaries and new patient assessment letters

Sir: The article by Dunn & Burton (*Psychiatric Bulletin*, June 1999, **23**, 355–357) highlighted the views of general practitioners (GPs) on discharge letters. I recently surveyed GPs in central Manchester on the same issue as part of an audit project. Specifically, I was attempting to investigate GPs views regarding discharge letters and new assessment letters.

I constructed a questionnaire for GPs which broke our existing letters down into 15 sections and asked them to rate on a five-point scale how useful they found that particular piece of information, ranging from one (essential) to five (irrelevant). The questionnaire also enquired about GPs opinions on letter length, whether they had time to read them and the speed with which they received the letters. Forty-eight of 77 GPs (62%) returned the questionnaire. GPs expressed broadly similar preferences over