Recent correspondence in the *Bulletin* and *Journal* emphasises the career difficulties for those of us applying for SR posts and the need to "publish something – anything". The number of papers published is seen as proportional to the likelihood of selection of the candidate. In the world of psychotherapy SR training, colleagues have told me that selection committees look especially for candidates who have affiliations with particular psychoanalytic institutions or even personal analysis with a well known figure. These are criteria on which the quality of the potential candidate is judged.

Surely while these measures may have some relevance in selecting a potential consultant psychiatrist or psychotherapist they leave out a good deal of data of a more subjective yet arguably equally important nature. What do the candidate's peers think of his/her quality of clinical care on the wards? Does the individual turn up on time to ward rounds, meetings and clinics? Do patients have to wait for him/her? Does he/she write clear concise clinical notes and helpful punctual letters to GPs? How do the clerical and ancillary staff view the trainee? But perhaps most important of all, does he or she possess the qualities outlined by Persaud & Meux (*Psychiatric Bulletin*, February 1990, **14**, 65–72) as important to psychiatric patients: empathy, a caring attitude and the ability to listen. Although these qualities are difficult to measure, it is surely our responsibility to start taking these issues into account in line with the Audits Commission's goals of economy, efficiency and effectiveness in our services.

I recently worked for 15 months in an out-patient psychiatry clinic in the USA linked with a health maintenance organisation. The chief psychiatrist in the clinic kept very careful records of all the staff's clinical hours and activities and we had a weekly meeting in which the multidisciplinary team discussed ways of improving our service and making it more attractive to the public and "user friendly". Regular retreat meetings were held away from our work place where interpersonal issues could be discussed in an open and democratic fashion. These meetings included the clerical and reception staff. This seems to me to be a step toward the kind of peer review that will be required for us to audit the process of our work in addition to providing valuable data for appointment committees faced with making difficult decisions. Perhaps this would also help selection committees to break away from their rather stifling overdependence on easy to measure data of questionable value in the choosing of future consultant psychiatrists and help in selecting empathic human beings as a priority of as much value as "Honoured Scientists".

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Beyond 'community care'

DEAR SIRS

The Mental Deficiency Act of 1913 empowered town councils to provide residential services for people now called mentally handicapped or with severe learning difficulty. In the 1950s the NHS in the Leeds, later the Yorkshire, region – population 3,000,000 – had over 3,000 hospital beds for mental handicap. A peak of just over 4,000 beds was reached in 1966 on a basis of the then norm of 1.3 beds per 1,000 of population.

Since then, the numbers have fallen to 3,400 in 1980, 3,100 in 1983, 2,500 in 1986 with a rapid drop to around 1,700 in 1990 due to the care in the community initiatives. Had the run-down continued at the same rate as during the '70s, it would have been the year 2040 before the hospitals were empty. If the present closure policy continues there should be virtually none of the original hospital beds by the mid-nineties.

In lecturing on the evolution of services I am struck by the guarded response from many young students and trainees, as well as older professionals and parents and relatives of patients, who might be naturally reactionary, to the Gadarene swine-like rush to close down mental hospitals, even though the Department of Health repeatedly claims that closure is not a primary aim. Life never stands still and it prompts the question as to what will be the next step in the evolution of services when the present institutions have vanished without trace.

In a generation or two will a revolutionary idea emerge, i.e. to create a residential centre where people with severe learning difficulty would live in an environment adapted to meet their needs and abilities? Instead of their living isolated in scattered small residencies with costly time-consuming transport to day care they would have their own campus. The centre would have a resource, research, study and teaching function for therapists, teachers, carers and others involved. The centre would develop a collegiate style of life for mentally handicapped people which they would have the right to choose, no less than others who go to a residential college or university.

The above is what many parents and relatives and open-minded professionals suggest some of the hospitals for mental handicap could have become today.

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An experience with the implementation of psychotropic law in Kuwait

DEAR SIRS

Substance abuse has been a growing problem over the past few years in developed as well as developing

countries. It has generated considerable concern among the public and the media and has created a controversial debate concerning such issues as the limits of personal freedom to abuse drugs. The line of demarcation between the justifiable use of a substance and the abuse that endangers life and social structure is highly contentious. The arrival of new drugs and the shifting of drug fashion has magnified that difficulty. The United Nations called upon its members to act individually to combat narcotics and related substances. In response Kuwait introduced a law (74) to combat narcotics and to regulate their medical use on 18 April 1983. This did not include most psychotropics and this prompted the Government to enact another law (48) on 1 September 1987 which became effective six months later on 1 February 1988. The basis of the law was in accordance with the convention on psychotropic substances, 1971, containing the list of psychotropic substances under international control as listed in Schedules I, II, III & IV including hypnotics, minor tranquillisers, stimulants and some antiepileptics.

In relation to psychiatry we discuss:

Points of difficulty

(1) It required that doctors should prescribe psychotropic drugs on three copies of the prescription with many details. This has substantially increased the workload of doctors in general and psychiatrists in particular.
(2) The title written on the prescription of psychotropic drugs has increased the stigma among patients, families and society.
(3) It generated among the media a false idea of correlation between narcotics and psychotropic drugs.
(4) It emphasised a preconceived idea that psychiatrists treat their patients with drugs which are habit-forming.
(5) Some doctors refrain from prescribing drugs even when indicated, some avoid over clerking, others avoid taking responsibility.
(6) It has created a split of opinion among psychiatrists as there has been an antipsychiatry campaign. Unfortunately some psychiatrists were sympathetic to that campaign and even their attitude to treatment with drugs and ECT has contributed to its momentum. The debate on benzodiazepines has been opened wide.
(7) It deprived some patients of the benefits of available drugs that could have helped them.
(8) Compulsory detainment of abusers who refuse treatment and cooperation proved to be useless as both the Prosecutor and the Court refuse to implement the alternatives to treatment.
(9) Some pharmacists, assistant pharmacists, nurses and even doctors became victims of investigations in alleged trafficking.
(10) Some antiepileptics were included in the schedule and these patients were running into difficulties.
(11) If the police arrested someone accused of trafficking, medicines were taken and, if actually a patient, he might have suffered, for example, epilepsy, cardiac trouble.
(12) It has increased the work for psychiatrists since patients who need psychotropics in general practice are mostly referred for management.

Points in favour

(1) The allegation of liberal prescription of benzodiazepines by psychiatrists leading to addiction proved to be wrong. The majory of prescribing came from non-psychiatrists, mainly general practitioners, followed by other disciplines of medicine and last psychiatrists.
(2) Benzodiazepines prescriptions have dropped to about one-third, reducing the budget in that area.
(3) Drug abuse appears to have reduced, probably changing to some other areas.
(4) Doctors, general practitioners and psychiatrists were relieved from the pressure of responding to the demand for certain drugs.
(5) It helped the psychiatric hospital divert efforts to improving the service given to other patients. Addicts and abusers, although having a separate out-patient clinic, used to linger among the facilities annoying other patients and personnel.

A committee, including consultant psychiatrists, physicians, neurologists, pharmacists and senior officials from the Ministry of Interior, Customs, Justice and Law Department, has been set up to study the problems and make recommendations. We believe it is wise to reject the two extreme positions, that psychotropic substances are an unmitigated evil or that these drugs are free of side-effects and cause no problems. The truth is to be found in the middle ground and the area needs constant surveillance and research. However, the enormous value of many of these drugs when properly prescribed should not be underestimated (The Royal College of Psychiatrists, 1987). Also, we believe that international cooperation between centres is greatly needed to tackle the dilemma of substance abuse in our area.

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Reference

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This letter was received on 26 June 1990.