Illicit drug misuse in mental health units

Sir: We were interested to read Williams & Cohen's (*Psychiatric Bulletin*, February 2000, **24**, 43–46) reminder of the difficulties for front-line staff in managing the problem of illicit drug use in mental health units. They suggest that "clear procedures to control substance misuse are necessary . . . for the legal protection of staff" in addition to policies covering patient and visitor searches, consultation with local police and "how far can and should confidentiality be protected".

Their comments are pertinent in light of the recent sentencing of two Cambridgeshire hostel workers to four and five years' imprisonment under the 'Premises' section of the Misuse of Drugs Act, which makes it a criminal offence for third parties to knowingly permit heroin or cannabis use in their property, in this case a homelessness day centre (*The Guardian*, 10 December 1999). Although suspected drug dealers were banned from the centre, staff refusal to give the names of alleged drug users to the police on the basis of confidentiality was seen as 'deliberately obstructive' behaviour.

With the reported prevalence of comorbid psychotic and substance misuse disorders being high and with such patients spending longer in hospital (Menezes *et al*, 1996), legal issues surrounding the presence of alcohol and drugs in mental health units are bound to occur. It would be detrimental to an already (dually) disadvantaged group of patients if staff felt unsure or even afraid of the legal consequences of their management relating to prohibited substances and we too urge trusts to offer clear guidance for the protection of both patients and their staff.

Reference

MENEZES, P. R., JOHNSON, S., THORNICROFT, G., *et al* (1996) Drug and alcohol problems among individuals with severe mental illness in south London. *British Journal of Psychiatry*, **168**, 612–619.

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Time for locked drug free psychiatric wards?

Sir: Illicit drug use is endemic in our society, and therefore also in our hospitals. Psychiatric hospitals look after a particularly vulnerable patient group in which drug misuse complicates management and can lead to accidental death. In the article by Williams & Cohen (*Psychiatric Bulletin*, February 2000, **24**, 43–46) they point out gaps between hospital policy and practice, in the context of clinical governance. However, I feel this only begins to address one of the fundamental issues. The issue is tolerance of people's lifestyles particularly when an in-patient is held, using a Mental Health Act section, against their will. However, something is wrong if this tolerance puts at risk other patients through the availability of drugs on a ward because the 'culture' is one of drug use among the peer group. Discharge is not always an option due to the clinical condition of the patient and the element of 'proof' of supply is always a difficult task. At the current time staff struggle on with limited support and develop an increasingly antagonistic attitude to 'drug users'. An accident is waiting to happen, and the hospital trust could be seen as liable.

The options, as I see it, once all patients are screened on admission for illicit drugs in or on them, is that drug users go to the 'open drug' wards. The other patients being put in 'drug-free' wards. Alternatively, if the concept of open drug wards is a step too far, then the patients who would have gone to the open drug wards instead go to a locked drug-free psychiatric ward. However, even in a locked unit it is difficult to keep drugs out, but at least it would protect other patients who need and want to be in a drug-free environment.

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Use of the Mental State Examination by psychiatric trainees

Sir: I agree with Kareem & Ashby (*Psychiatric Bulletin*, March 2000, **24**, 109–110) that the Mental State Examination (MSE) is fundamental to psychiatric evaluations. The result of their audit showing inadequate recording of the MSE by psychiatric trainees, although the presentation of the data begs a number of questions, is, therefore, a cause for concern.

A "standardised format" is suggested as the solution lest trainees should "employ their discretion" such that "important MSE headings and parameters are often unexamined and unrecorded". The implication is that as long as every box on the audit sheet can be ticked then all will be well with the world. Surely the important thing is the content and quality of the MSE and that it meaningfully relates to the patient's condition at the time. Of course, the form in which this information is set out is relevant, but making an industry out of this is to miss the point. There is, excluding hair-splitting, a well-established convention for recording the MSE and a trainee forgetting to ask about abnormal perceptions (or indeed to examine the nervous system) is down to the trainee and not to the absence of a proforma.

I would also argue that it is self-evidently the responsibility of the consultant, as the educational supervisor of the trainee and the doctor in charge of the patient's care, to review the quality of information in the case notes, including admission-clerking and MSE, as well as admission and discharge summaries and clinic letters. How else is one to know what the standards, strengths and weaknesses of a trainee in these important areas are and, therefore, to be in a position to help them to address any shortcomings and contribute to an improved level of clinical care? The audit process can be useful, but is not an alternative to the fundamentals of good practice or the rigorous clinical teaching of trainees, nor should it have to be a means to this end.

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Implications of community treatment orders

Sir: I should like to comment on some of the points made by Llewellyn-Jones & Donnelly (*Psychiatric Bulletin*, March 2000, **24**, 16–17) in their letter about community treatment orders (CTOs). First, they minimise the importance of the side-effects of medication. These are not only extrapyramidal in nature, but encompass a large number of other undesirable symptoms, which many patients, quiet reasonably, do not wish to experience. Their observation that tardive dyskinesia can occur in patients who have never taken medication is a non-sequitur – would they similarly dismiss the role of smoking in causing lung cancer on the grounds that some people who do not smoke also develop the disease?

Second, the suggestion that psychiatrists might have a 'duty' to enable their patients to comply with treatment in the community is a dangerous one, as it implies that in certain circumstances we are 'morally obliged' to go against people's wishes for their own good. This is a familiar argument which has been used to justify various forms of coercive and/or radical treatment (including psychosurgery – see for instance William Sargant's (1967) *The Unquiet Mind*). No doubt psychiatrists, just as much as doctors in other fields of medicine, would like their patients to comply with the treatment

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they prescribe and feel that they would be better off as a result. Whether this should be enforced by legislation is another matter.

Compulsory treatment in the community raises important issues, several of them discussed in the original article by Moncrieff & Smyth (*Psychiatric Bulletin*, November 1999, **22**, 544–546). Many mental health workers are justifiably concerned about the implications of CTOs for the relationship between professional and patient as well as for individual patient rights. I do not think that Llewellyn-Jones & Donnelly offer persuasive arguments in their favour.

SARGANT, W. W. (1967) *The Unquiet Mind: the Autobiography of a Physician in Psychological Medicine*. London: Heinemann.

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Help cards for patients

Sir: We wish to report our experience of developing a help card for patients who commit deliberate self-harm (DSH) attending a general hospital. A previous local study identified difficulties with assessments and planning interventions (Gordon & Blewett, 1995). In Bristol the effectiveness of offering access to specialist telephone help following DSH has been examined with variable outcome between subgroups (Evans *et al*, 1999) demanding further study and replication. We propose a slightly different intervention as part of a broader strategy. We asked casualty doctors to offer a pocket-sized card with numbers and hours of availability comprising the Samaritans, Relate, a local alcohol and drugs agency, a line for young people, Rape and Incest crisis, and the National Debt line.

As a first step to understanding its impact we wrote to people discharged from an accident and emergency department after committing DSH. Forty-eight patients returned a questionnaire, of whom 20 reported receiving a card. Of these, 15 thought it a good idea, and six of the seven who used a line said that they found it helpful.

If a voluntary sector based card could be shown to be effective, the implications for joint working are obvious: currently there is a paucity of evidence for voluntary sector DSH interventions generally, and a variety of arrangements between statutory and voluntary sectors have grown up in different localities. The objective value of our findings is limited to an impression of user acceptability. In an attempt to examine the effect on repetition of DSH, the card is now subject to a randomised controlled trial, and forms part of our patients' management delivered by a specialist DSH team. We would value the opportunity to share our experience with others interested in treating this patient group.

References

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GORDON, C. & BLEWETT, A. (1995) Deliberate self-harm: service development in Kettering. *Psychiatric Bulletin*, **19**, 475–477.

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Use of Section 62 in clinical practice

Sir: Like Johnson & Curtice (*Psychiatric Bulletin*, April 2000, **24**, 154), we have also audited the use of Section 62 (urgent treatment). We studied all Section 62 forms completed at St Andrew's Hospital during 1997. A total of 55 forms were audited, 53 authorising medication and two authorising electroconvulsive therapy (ECT). This contrasts with Johnston & Curtice who found Section 62 was used exclusively for ECT. These findings are likely to be due to differences in patient characteristics between the two studies. St Andrew's has many tertiary NHS referrals including forensic patients, whereas Johnson & Curtice were studying patients of a local psychiatric service.

In our audit, aggression towards self or others and generally disturbed behaviour were the most common reasons for using Section 62. Antipsychotics followed by benzodiazepines were the most frequently administered medicines. In 33 instances patients receiving treatment authorised by Form 39 urgently required additional medication to that certified. Fourteen patients withdrew their consent to treatment at the same time displaying an urgent need for medication. A disproportionate number of Section 62 cases involved adolescent female patients. In virtually all cases treatment authorised by Section 62 appeared genuinely urgent.

We are concerned about the Government Green Paper *Reform of the Mental Health Act 1983*. It proposes that the threshold for administering emergency medication be increased such that merely preventing violence or self-harm would not be sufficient grounds to authorise urgent treatment. This raises concern about staff and patient safety particularly in forensic settings. Psychiatrists will no longer be able to give urgent ECT to patients who lack capacity or do not consent but must wait for authorisation from a second opinion appointed doctor (SOAD). In our audit SOADs took a mean of 4.8 days to visit and complete Form 39 after Section 62 had been used. If made law this measure is likely to increase the suffering and morbidity of severely depressed patients.

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C. KATONA, S. P. TYRER AND J. SMALLS

Changes to the MRCPsych examinations

The MRCPsych Examinations were analysed by a professional educationalist, Dr Helen Mulholland, in 1998 and a working party, chaired by the Dean, was set up to examine what changes would be desirable to increase the reliability and validity of the Examination, and to ensure it is in keeping with the principles of 'adult learning'. In June 1999 the working party agreed that an option appraisal should be made of the alternatives proposed, and that this should be subject to a wide ranging consultation process with all relevant parties. The final recommendations were considered and agreed by the Court of Electors in December 1999.

Part I Examination

At present the Part I MRCPsych Examination consists of a multiple choice

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