Psychiatric Bulletin (1990), **14**, 42–47

Correspondence

Workshops on court procedures

DEAR SIRS

I was interested to read Dr Healey's letter describing his experience of the High Court (*Psychiatric Bulletin*, October 1989, **13**, 570–571). As he found, the rules of legal procedure, such as that answers to barristers' questions should be addressed to the judge, are not obvious. At a recent residential meeting of the Child & Adolescent Psychiatry Section of the College, I attended a workshop run by a judge which included role play of an expert witness undergoing cross-examination. The legal conventions and court procedures rapidly became clear as did some of the assumptions which lawyers or judges are likely to make in considering cases involving children.

I would like to suggest that workshops of this sort could be a very useful training experience for child or adult psychiatrists. There is scope both for experiential learning about court procedures and for acquiring an understanding of how lawyers and judges think about psychiatric or child care issues. Psychiatrists at the workshop expressed discomfort with the adversarial legal system but it was interesting to hear the judge's alternative view that the maximum "truth" about a case might be reached through it. Although child psychiatrists may be seeking changes in legislation and court procedures, we also have to work within the system as it is and I agree with Dr Healey that we should be careful to learn its rules.

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Mental health review tribunals

DEAR SIRS

Unless I have misread Dr Petrie's question (*Psychiatric Bulletin*, October 1989, **13**, 571), I would venture to suggest that the answer may be found in Section 131 of the Mental Health Act (Subsection 1) where it states that nothing in the Act shall be construed as preventing a patient "from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be so liable to be detained". It is, of course, unlikely that such a practice would apply to a patient who had been detained in a special hospital but I would submit, at least in theory, that such an informal admission could occur in the case of a patient who had been detained under a restriction order in an ordinary psychiatric facility and then discharged. It would be interesting to have other views upon a matter that has interesting implications.

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Forensic questions in the multiple choice paper

DEAR SIRS

I have read the letter from Twelve Angry 'Men' in the *Psychiatric Bulletin* of September 1989 with interest. I would suggest that the Examination Sub-Committee should think very carefully before changing the thrust of the forensic questions in the multiple choice paper, as the authors of this letter suggest. I agree with Professor Morgan that matters relevant to forensic and legal psychiatry are indeed of immense importance and this is no less relevant to Irish and Scottish candidates, many of whom apply for jobs in England and Wales after they have passed the Membership. If it were the general rule that Irish and Scottish candidates stayed in their own countries for the rest of their training and as consultants, then there would perhaps be a case for including more questions relating to their own jurisdictions, but this is not so at the present time. However, some knowledge of the Scottish system is relevant to Irish and English trainees who move to Scotland and there may well be more case for including questions relating to the Scottish system in the examination. It is true, however, that there are many general questions which do not relate to matters of law that can be asked and perhaps a few more of these could be considered in future.

I am not a member of the Examination Sub-Committee.

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Suicidal patients – the effect on staff

DEAR SIRS

Dr Rossiter (*Psychiatric Bulletin*, September 1989, **13**, 495–496) found several of her nurses to have a pessimistic attitude towards their patients when

interviewed after their suicide. She wonders if the nurses held the same views before their patients' deaths and if this could be relevant to the patients' subsequent suicides.

Similar but slightly differing views have been offered by other researchers concerning in-patient suicides. Farberow *et al* (1966), in a study of suicides among Veterans Administration patients, labelled some of these patients as having "dependent dissatisfied personalities". They made insatiable demands on staff for special attention and in the end alienated themselves from professional help. Similarly, Flood & Seager (1968) found many of those psychiatric patients who committed suicide had difficulty in settling into hospital and accepting treatment. Many took their own discharge, and in some instances, staff commented that their symptoms were "put on". Morgan & Priest (1984), in another study of suicides among psychiatric in-patients, describe a process they label as "terminal or malignant alienation". In the last few weeks of their lives, a considerable number of their patients lost support from important others. In many cases the ward staff became critical of their behaviour, describing it as provocative, unreasonable and over-dependent. Again, staff perceived these patients as "putting on" or magnifying their disabilities in order to gain attention.

It is important that all staff working with psychiatric patients should be aware of this process of "malignant alienation" and should recognise that it may have serious consequences. Working with demanding and chaotic patients imposes enormous strains on nursing staff in particular. Staff need a time and place to express and to try to understand their negative feelings towards these patients. A weekly staff sensitivity meeting, with an outside facilitator, should provide a suitable venue for such discussion.

Another useful preventive measure is the concept of an "at risk" register. At St Mary Abbots, each of the three consultant led multidisciplinary teams draws up a list of patients who are seen as vulnerable, liable to do themselves harm in one way or another and who are not in proper contact with the service. The register helps us to focus our attention on those at risk. It is reviewed each week in the ward round. Appropriate action is decided upon and then fed back to the meeting at a later date.

Finally, the psychological impact of a suicide on the in-patient unit has been analysed by Bartels (1987). He outlines a four stage process a unit goes through: shock, recoil, post-trauma and recovery. He suggests how members of the community can support and help each other in the event of such a tragedy. Staff may face a dilemma between feeling the suicide is unavoidable, hence freeing themselves from self-blame but resulting in feelings of helplessness and therapeutic nihilism, or feeling the team has made some sort of an error and is to blame, whereupon some individuals may feel overwhelmed with guilt. Here a psychiatric post-mortem, or unit review of the death, may help staff gain a clearer perspective on what has happened. Such a review also helps us to correct and identify short-comings in the service and hence improve our standards of care.

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References

BARTELS, S. J. (1987) The aftermath of suicide on the psychiatric inpatient unit. *General Hospital Psychiatry*, **9**, 189–197.

FARBEROW, N. L., SHNEIDMAN, E. S. & NEURINGER, C. (1966) Case history and hospitalization factors in suicides of neuropsychiatric hospital patients. *Journal of Nervous and Mental Disease*, **142**, 32–44.

FLOOD, R. A. & SEAGER, C. P. (1968) A retrospective examination of psychiatric case records of patients who subsequently committed suicide. *British Journal of Psychiatry*, **114**, 443–450.

MORGAN, H. G. & PRIEST, P. (1984) Assessment of suicide risk in psychiatric in-patients. *British Journal of Psychiatry*, **145**, 467–469.

Training in psychogeriatrics

DEAR SIRS

The findings of Watson & Jolley (*Psychiatric Bulletin*, September 1989, **13**, 514–516) on higher specialist training in the psychiatry of old age and the yield of consultants make encouraging reading. Those of us who sit on Advisory Appointment Committees may hopefully look forward to relief from the grim ritual of making no short lists or appointments from a field largely comprised of locum consultants with no senior registrar training of any kind.

The recommendation of JCHPT 1987 that serious career minded psychogeriatricians should spend more than one year and preferably two in the specialty leaves me with a certain amount of unease. This recommendation should never be allowed to militate against the option of a senior registrar having a one year affair with the specialty which might lead on to a stronger commitment to a further year living together before the final marriage. Our rotational training schemes of one year in West Lambeth over the last six years have yielded three consultant psychogeriatricians with two senior registrars intent on following a career in the psychiatry of old age.

Psychogeriatrics, like Guinness, is an acquired taste; those who wish to imbibe must not be discouraged if they wish to become serious career minded drinkers!

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