Correspondence

CPA: should it carry a government health warning?

Sir: Watson (*Psychiatric Bulletin*, July 1997, **21**, 432–434) described a recent "aversion experience" of using the Care Programme Approach (CPA). Watson claims that a CPA meeting held with a client, referred to as B., precipitated a violent suicide attempt. Although described by Watson as, "The last straw which triggered her behaviour", the CPA is set up as the villain of the piece. Several other possible stressors were identified by Watson and B., including the imminent departure of B.'s keyworker, B.'s approaching discharge from hospital, and B.'s fear of Watson's impending retirement. In concert, these factors would plausibly provide a sufficient trigger for a vulnerable individual, but it is a CPA needs assessment meeting that is made to shoulder the blame.

In general, Watson labels the CPA "reductionist", and considers it to be a waste of valuable clinical time. Watson goes on to say of B. that, "her 'needs' were for love, for closeness, and for something to fill up the sense of emptiness, not the list we had written on the page (CPA form)"; and comments that, "A need for closeness and holding do not fit easily into the CPA form." They should not. These are inappropriate objections to an approach designed to promote good professional practice. Could one even imagine a 'professional' psychiatric system for the provision of love, closeness, and existential fulfilment? It is strangely naïve to complain that the CPA is not a life-partner.

Watson offers, honestly, that, "On this occasion I did not pick up the degree of distress which the patient was feeling, in spite of knowing her very well indeed"; but complains that it was the setting of a CPA needs assessment meeting that made it difficult to attend to B.'s emotional state. To make the CPA the scapegoat for a simple lapse in professional sensitivity is unreasonable.

It would be a shame if these misplaced objections to the CPA were to deter Watson and other professionals from carrying out the comprehensive assessment of needs that is a central pillar of the CPA's formalisation of good practice.

JASON WHEELER, *Department of Psychiatry, De La Pole Hospital, Willerby, Hull HU10 6ED*

Sir: I would like to thank Dr Wheeler for responding to my account of a recent experiment of using the CPA. The points he raises are interesting, but they reflect a lack of understanding of what I was attempting to demonstrate. My main aim was to point out the patient's perception of the process. He claims that I unfairly portrayed the CPA as the "villain of the piece", when it was the patient who had clearly reported that for her it was indeed the last straw. The other factors mentioned were obviously important and I was careful not to ignore them.

He has interpreted my comment that the need for love, closeness and understanding do fit on the CPA form literally as my "naïve wish for it to be a life-partner". Clearly this is not my wish. The point was the patient's awareness that "needs" as written on the page were very inadequate to describe what she was feeling and that the discrepancy resulted in distress.

As for the "lapse in professional sensitivity": surely, unless we try to examine which elements in the interview or surroundings contribute to such lapses, we risk repeating them. My hope was that the account would stimulate some thought about the CPA process so that there would be less likelihood of a blind acceptance of it.

P. E. WATSON, *Consultant Psychiatrist, Derwent Clinic, Shotley Bridge General Hospital, Shotley Bridge, Consett, County Durham DH8 0NP*

Tardive dyskinesia – how is it prevented and treated?

In their otherwise outstanding review of current knowledge regarding the treatment of tardive dyskinesia (TD) (*Psychiatric Bulletin*, July 1997, **21**, 422–425), Duncan *et al* significantly underestimate both the quantity and quality of the evidence regarding the efficacy of clozapine in the treatment of TD.

Although two early double-blind studies with a total of 15 patients failed to demonstrate a beneficial effect of clozapine on TD, these were brief, used extremely small doses and came from the same group (Casey, 1989). There have since been 10 studies, nine open and uncontrolled with a total of approximately 200 subjects from six different centres (see Young *et al*, 1997), and one an elegant double-blind study which compared clozapine to haloperidol plus benztropine in 32 patients (Tamminga *et al*, 1994). All the open-label studies found a significant reduction in TD, with scores on the Assessment of Involuntary Movement Scale reduced by greater than 50% in 40–100% of patients, and complete

https://doi.org/10.1192/pb.21.11.723 Published online by Cambridge University Press