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correspondence

Could the development of an interactive website facilitate communication between psychiatric trainees?

Effective and efficient communication between junior doctors in a training scheme is important if their training needs are to be fully met. As such the College requires that each training scheme has a trainees' committee. Effective communication is important in terms of trainee representation but can be difficult when training schemes are spread over a large geographical area. Electronic communication may overcome this problem and provide additional benefits (Huang & Alessi, 1996).

We wished to ascertain how well trainees understood their local system of representation and to canvas opinion about whether a website could facilitate this representation. A questionnaire was sent to trainees within the northern region of England; 73 out of 179 (41%) trainees responded to the questionnaire. Although only 48 respondents (65%) reported having received minutes of the trainees' meeting, all had access to the internet. Most trainees (65, 89%) welcomed the suggestion of the development of a website. Factors identified that would encourage use of the website included an examinations section, study tips and advice, and a discussion forum. A website for trainees in the northern deanery was therefore developed (<http://www.northernpsychiatrytrainees.com>) to address these issues. Its use by and acceptability to psychiatric trainees at all levels will be monitored.

HUANG, M. P. & ALESSI, N. (1996) The Internet and the future of psychiatry. *American Journal of Psychiatry*, **153**, 861–869.

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Terrorist detainees – psychiatry or morals?

Robbins *et al* (*Psychiatric Bulletin*, November 2005, **29**, 407–409) describe the mental states of a number of men detained in HMP Belmarsh without trial or charge. They all appeared to be experiencing significant levels of psychiatric morbidity. The authors go on to state that this is a result of the indefinite nature of their custodial detention, although there is no evidence to support this hypothesis in their paper. This is an important subject, and one about which psychiatrists have been silent until the authors' contributions. My concern, however, is that this is really moral philosophy masquerading as psychiatry. What is implied in the paper is that detention without trial or charge is abominable. However, this is a moral argument plain and simple that is just obfuscated by discussion of the men's psychiatric states. It seems to be saying that because these men are unwell and made worse by being in prison, we should not put them in prison. Given the well-established and striking levels of morbidity in the ordinary prison population, one might think the same argument applied for all prisoners *a fortiori*. However, this all seems to miss the point. I think the situation would be just as abominable even if the authors had shown the men to have become much healthier during their time in custody. Where are the voices of psychiatrists in this moral debate about whether imprisonment without trial or charge is right? Are we unable to speak about that without a cloak of pseudoscience?

Declaration of interest

S.W. worked as a Clinical Research Fellow in Forensic Psychiatry at HMP Belmarsh between 2001 and 2002 and considers detention without charge or trial to be wrong.

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Exploitation of senior house officers

I note with interest that although the *Basic Specialist Training Handbook* clearly

states that 'training placements should not include inappropriate duties (e.g. routine phlebotomy, filing of case notes, escorting patients, finding beds, etc)', this is flouted routinely by some hospitals. Various excuses such as lack of personnel and shortage of funds are given and the trainees are expected to 'get on with it'.

This practice is nothing short of exploitation and what makes it worse is that many consultants and educational supervisors look the other way. I feel that the College will have to do more than just mention 'inappropriate duties' in a handbook. It is my belief that this exploitation will not go away until the College deals with it proactively and firmly.

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Psychotic offenders and prison

I recently assessed a man on behalf of a mental health review tribunal who had been diagnosed with schizophrenia some 14 years into a life sentence. He was then treated for the next 15 years in prison for this condition without the benefit of an assessment as an in-patient in a National Health Service (NHS) hospital. In prison his symptoms were not completely controlled and in a paranoid state he wrote abusive letters to the staff. He failed to get parole. His condition fluctuated and finally, in 2005, he was transferred under Section 47/49 of the Mental Health Act 1983 to an NHS regional secure unit. He was described on admission as actively psychotic. New treatment was started with excellent results. By the time I assessed him on behalf of the mental health review tribunal he had lost his symptoms of psychosis.

My colleague has told me of two men recently seen, both of whom had offended as a result of the psychotic state they were in at the time. Each was, quite properly, placed in psychiatric hospital while awaiting trial. Both had recovered by the time their separate trials were heard and no longer needed to stay in hospital. Instead of their treatment being continued in the community they were, astonishingly, sentenced to imprisonment.



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I raised the subject with The Chief Inspector of Prisons. She replied that '... prolonged treatment in prison is indeed an all too common way of managing psychotic prisoners.' She also reported that although arrangements to transfer prisoners from prison to hospital are better than they once were, there are still delays of months – much too long a time for a psychotic patient.

A prison is not designed to provide the level of expert care of a psychiatric hospital nor is it a community appropriate for the care of a person with chronic psychosis. How can we as a profession tolerate the present state of affairs?

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Assessment of capacity: a medico-legal challenge for decision makers

Dr Jones, in her comprehensive article (*Psychiatric Bulletin*, November 2005, **29**, 423–427), provides a review of the Mental Capacity Act 2005. The Act aims to provide a statutory framework to protect vulnerable people who may not be able to make their own decisions.

To ascertain current practice of local services as regards to assessment of capacity, we examined 60 randomly selected case notes of patients with learning disability in Lincoln (15

in-patients, 45 in the community; 42 males, mean age=41 years, s.d.=13, range 18–67).

Review of case notes revealed that patients needed to make a decision regarding their medication (36 patients), admission (15 patients), placement (6 patients), financial issues (2 patients) and a sexual relationship (1 patient). We found recorded evidence for assessment of capacity in 13 case notes (22%). Clinicians had allocated more than one appointment in two-thirds of cases and used alternative and augmentative communications (sign language, Makaton and picture books) in 33 cases (55%) to facilitate patients' decision-making.

Our study also revealed the involvement of carers in a high proportion of cases (45, 75%) and reasonable consideration for patients' wishes (24 cases, 40%) but little evidence of involvement of advocates (3 cases, 5%) and financial safeguard (2 cases, 3.3%).

The assessment of capacity and detailed documentation required by the Mental Capacity Act 2005 will be a challenge for busy clinicians. Failure to implement safeguards for those who lack capacity will not only jeopardise the quality of care provided but will also infringe on patients' human rights and make decision makers vulnerable to lawsuits.

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Cholinesterase inhibitors and Alzheimer's disease

Simpson *et al* (*Psychiatric Bulletin*, November 2005, **29**, 410–412) state in their audit of the use of cholinesterase inhibitors that stopping these drugs in the latest stages of dementia 'is poor clinical practice and likely to have adverse outcomes'. They base this opinion on the fact that many of the patients in their sample deteriorated or died after their memory enhancers were discontinued when their Mini-Mental State Examination scores fell below 12. The authors acknowledge that this high death rate could be because the patients who deteriorated or died were probably the most physically ill. In fact, this would be the simplest and most likely explanation. Therefore, the conclusion that stopping these drugs in the advanced stages of dementia constitutes poor clinical practice is really unfounded and could only be supported after the hypothesis is tested successfully in a controlled trial.

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