DAVIES, A. G., DOMINY, N. J., PETERS, A. D., *et al* (1995) HIV in injecting drug users in Edinburgh: prevalence and correlates. *Journal of AIDS and Human Retrovirology*, **8**, 399–405.

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Service contact prior to suicide

Sir: We were interested to read Meats & Solomka's perspective on suicide in Central Nottinghamshire from 1987–1991 (*Psychiatric Bulletin*, **19**, 666–669) and their points regarding consulting behaviour and potential for intervention.

We conducted a survey of Nottingham suicides during 1994. Data were collected from Coroner's records, hospital database and a postal questionnaire (75% returned) from general practitioners (GP) who encountered suicides, or open and misadventure verdicts judged as suicides. Fifty-seven deaths by suicide were identified (7.8 per 100 000 pop.), 75% male, and 54% men under 35 years.

We wish to make two points. Firstly, a considerable number of Meats & Solomka's "non-consulters" (i.e. no primary or secondary service contact in 12 months prior to death) may have attended casualty or non-psychiatric medical services within this time. In our sample 37% of cases had attended casualty (often with deliberate self-harm), and 32% other medical services, and for seven cases casualty was their only contact. These casualty attenders in particular represent a significant group since they are at known risk of death within one year of DSH and suggest potential for targetable intervention in a readily identifiable group. This compares with identification of potential suicides within primary care, a comparatively rare event estimated as one in 51 199 GP consultations (MacDonald, 1992).

Secondly, although GP consultations by potential suicide cases increased before death and provided an "opportunity to be recognised", in our study the issue of suicide was not raised with over half of cases despite recognition of psychological distress in 67% cases and prior DSH in 29%. Indeed, only one of 43 GPs thought their particular suicide cases preventable, suggesting an overall reluctance by GPs to see suicide prevention as practically relevant to them.

MACDONALD, A. (1992) Suicide prevention by GPs? *British Journal of Psychiatry*, **161**, 574.

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Distinction awards

Sir: Dr Hyde (*Psychiatric Bulletin*, **20**, 117) reports that consultants who change posts may be inadequately considered for C distinction awards (now 'discretionary points') because their achievements in a previous position are not known.

There is another hazard that also applies to higher awards. Distinction awards are based on merit not seniority but award committees are favourably influenced by the duration of consultant responsibility. In the case of consultants who change posts their date of achieving consultant status is sometimes recorded for award committees as the date of last appointment. The error of course shortens by some years the true period of consultantship.

Consultants who change jobs would be wise to ensure that their new Regional Health Authority and the Secretariat of the Advisory Committee on Distinction Awards register for this purpose the first date of consultant appointment.

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The rise and fall of anti-psychiatry

Sir: Nasser (*Psychiatric Bulletin*, **19**, 743–746) makes some interesting points, several of which merit comment. Cooper defines "anti-psychiatry" quite specifically in *Psychiatry and Anti-Psychiatry* (1970), a text cited by Nasser. Cooper's aim appears to have been to coin a term which specifies a practice which is the converse of orthodox practice. His use of the term is clear:

> "A more profound questioning has led some of us to propose conceptions and procedures that seem quite antithetic to the conventional ones – in fact what may be regarded as a germinal anti-psychiatry."

Commentators have often misunderstood the term as simply one more way of expressing antagonism to orthodox psychiatric practice rather than an antithesis. This mistaken use of the term loses the subtlety of the original, and is often misapplied to a heterogeneous collection of views, many of which would have found approval with Cooper or Laing.

Laing and anti-psychiatry are taken to be synonymous by some authors but he appears not to promote the term in his writings, to have neither made a contribution to, nor offered an endorsement of Laing and Anti-Psychiatry (1971) and in *Wisdom, Madness and Folly* (1985) wrote

> "I have never called myself an anti-psychiatrist, and have disclaimed the term from when first my friend and colleague, David Cooper, introduced it".

On what basis does Nasser bracket Szasz with Cooper and Laing? Szasz has always written from the position of right wing libertarianism whereas Cooper and Laing were on the left wing of politics. Even linking Cooper and Laing in this way is suspect if we take Mullan's (1995) record of conversations with Laing as accurate. Here Laing's promiscuous interest in liberal thinkers contrasts with his portrayal of Cooper as a committee communist activist in exile.

Is there shared thinking between the three? One footnote apart, Szasz makes no mention of Laing or anti-psychiatry until *Insanity: The Idea And Its Consequences* (1987). Here he castigates Laing for claiming to be a doctor of non-illnesses. Laing appears to confirm Szasz's antagonism when reporting one encounter to Mullan (op. cit.). Prior to the Mullan publication Laing and Cooper only mention Szasz in three footnotes.

Arguably Szasz, Cooper, and Laing can be grouped as critics of orthodox psychiatry but can hardly be characterised as sharing any kind of platform.

These comments may be dismissed as debating points, but my main interest is in important questions implicit in Nasser's letter: Is critique of our work always to be experienced paranoically, as the barbarian at the gates? If self-critique by psychiatrists is to be routinely savaged should we dismiss out of hand the considered views of fellow professionals from other disciplines? Should we make the reflex assumption that representatives of MIND are engaged in a relentless moral crusade against all our profession stands for?

BOYERS, R. & ORRILL, R. (1971) *Laing and Anti-Psychiatry*. Harmondsworth: Penguin.
COOPER, D. (1970) *Psychiatry and Anti-Psychiatry*. St. Albans: Paladin.
LAING, R. (1985) *Wisdom, Madness and Folly*. London: Macmillan.
MULLAN, R. (1995) *Mad To Be Normal: Conversations With R. D. Laing*. London: Free Association Books.
SZASZ, T. (1987) *Insanity: The Idea And Its Consequences*. New York: Wiley.

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Sir: I stated that the anti-psychiatric movement grew in the realm of politics, particularly of the left. I did not say however that Szasz belonged to the left. Szasz's political views were seldom made obvious (Sedgwick, 1982). His views were commonly regarded as libertarian, anti-collectivist that focused mainly on the individual. Some saw an inherent contradiction in Szasz's political argument as he appeared more to the right than the prevailing capitalist structure that was the subject of his attack. My inclusion of Szasz with Cooper and Laing was unrelated to his political ideology, more that he belonged to the antipsychiatric movement and his premise was largely in keeping with that of Laing and Cooper.

It is difficult to see that the anti-psychiatric movement only represented a different view point or an *antithesis* that was not hostile to psychiatry. In Cooper's language of madness, he says

> "most victims of supposed madness, suicide are made victims by those who compulsively have to help . . . were it not for the stigmatisation, the institutionalising process, and the interference of doctors who have to justify their existence by the medical game of diagnosis, shocks and chemical euthanasia" (Cooper, 1980).

It is regrettable that the anti-psychiatric movement did not evolve or develop into a real antithesis to provide a much needed alternative view. It has certainly contributed in the past to lively debates about the nature of psychiatry and been probably instrumental in shaping existing psychiatric services.

The new community facilities have to a great extent rendered the psychiatrist physically and intellectually isolated. There is therefore a need to look at the structure of the training of other mental health professionals as well as our own. The point is to not live in the past, entertaining scientifically unfounded beliefs or indeed thinking only in terms of neurotransmitters. What is needed is to encourage the development of a discourse to enable the expression of other views, which are truly vital to the current state of psychiatric practice and its future.

COOPER, D. (1980) *The Language of Madness*. London: Pelican.
SEDGWICK, P. (1982) *Psychopolitics*. London: Pluto Press.

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Leave and detained patients

Sir:

> "Many still believe, incorrectly, that a detained patient may go on leave without the completion of Section 17 leave formalities if they are only going out of the hospital grounds for a short while or if they are escorted by staff."
> "Section 17 applies to the shortest period of absence. . . ."

These quotations from the 6th Biennial Report of the Mental Health Act Commission (MHAC) are perfectly clear – as long as we know what "hospital grounds" are. The term "hospital" is finally, unhelpfully, defined in Section 145, of the 149 Sections, in the 1983 Mental Health Act; grounds are not. "What is a hospital?" asks MHAC Practice Note 3, 1994. The question may