Correspondence

Early retirement on mental health grounds

Sir: I am referring to Dr Pastor's (*Psychiatric Bulletin*, November 1995, **19**, 705) letter. I too have been asked to prepare psychiatric reports for early retirement where the individuals concerned have not been treated for their condition. I am also concerned by the untreated people I am asked to see for personal injury claims following road traffic accidents or work accidents. They seem particularly reluctant to report psychiatric symptoms to their general practitioners.

It is especially difficult to reach out to these people with government-led pressure on purchasers to provide services for psychotic disorders above all else.

N. LONGHURST
Fair Mile Hospital, Reading Road, Cholsey, Wallingford, Oxon OX10 9HH

Assessment of insight

Sir: Assessment of insight is an important part of the mental state examination, particularly of patients with psychosis. Whether to admit, whether to detain and whether to medicate hinges on the apparent presence or absence of insight. It is difficult to understand the scant attention this issue receives in the textbooks and revision aids used in preparation for MRCPsych exams. Hopefully the resurgence of interest in the concept of insight (Markova & Berrios, 1992; David *et al*, 1995) and the teasing out into separate dimensions of awareness of illness, ability to relabel psychotic experiences and treatment compliance (David, 1990) will lead to improvements in future editions. Meanwhile, we would commend these papers as a thought-provoking introduction to a complex but essential area of clinical psychiatry.

DAVID, A. S. (1990) Insight and psychosis. *British Journal of Psychiatry*, **156**, 798–808.
—, VAN OS, J., JONES, P., *et al* (1995) Insight and psychotic illness: cross-sectional and longitudinal associations. *British Journal of Psychiatry*, **167**, 621–628.
MARKOVA, I. S. & BERRIOS, G. E. (1992) The meaning of insight in clinical psychiatry. *British Journal of Psychiatry*, **160**, 850–860.

ALEX BALDACCHINO
Fulbourn Hospital, Cambridge
GRAEME YORSTON
Amersham Hospital, Buckinghamshire

Sib-pairs with psychosis

Sir: My colleagues and I are conducting large-scale molecular genetic studies of both schizophrenia and bipolar affective disorder. We are currently trying to identify pairs of affected siblings where both have either schizophrenia or bipolar disorder. Our studies require several hundred pairs of both types. Participants are asked to undergo a standardised psychiatric assessment using a SCAN interview schedule (Wing *et al*, 1990) and to give a small blood sample for DNA analysis. If the patient does not wish to give blood then sufficient DNA can be extracted from a buccal smear.

I would be most grateful if any psychiatrists who know of suitable sib-pairs would contact me at the address below. Members of our research team will be able to visit the affected individuals to conduct the interviews and to obtain samples. Your help in this important project would be very much appreciated.

WING, J. K., *et al* (1990) SCAN: Schedules for Clinical Assessment in Neuropsychiatry. *Archives of General Psychiatry*, **47**, 589–593.

MICHAEL J. OWEN
University of Wales College of Medicine, Heath Park, Cardiff CF4 4XN

Clinical practice guidelines

Sir: Palmer (*Psychiatric Bulletin*, January 1996, **20**, 40–42) presents a useful insight into the rationale behind the development of the first of the clinical practice guidelines (CPGs) by the College. Such a survey reflects the importance of involving 'end users' in all phases of development (i.e. psychiatrists of all grades and other professionals who will be involved in implementation).

A systematic review of all the available research evidence into the effectiveness of CPGs in improving clinical practice has been produced (Effective Health Care, 1994). It concluded that good research evidence exists to demonstrate that guidelines can change clinical practice to improve patient outcome, and that "the methods of development, implementation and monitoring of guidelines influence the likelihood of adherence". For such guidelines to be effective, they should be based on the systematic identification and synthesis of evidence of clinical and cost

effectiveness and "recommendations should be explicitly linked to that evidence".

The College CPGs steering group intends to produce guidelines at a rate of two per year. In the interim, clinicians may wish to look at guidelines which are already in existence for a specific area of clinical practice. Criteria have recently been published (Hayward *et al*, 1995) which allow the clinician to critically evaluate the validity and utility of guidelines (including those which will be produced by the College) before adopting them in local clinical practice.

In the preparation of practice guidelines, I anticipate that many areas will be identified where the research evidence for the effectiveness of interventions is not available. It is hoped that this will demonstrate the need for further well designed and funded research.

EFFECTIVE HEALTH CARE (1994) *Implementing Clinical Practice Guidelines* (Bulletin No 8). Leeds: University of Leeds.

HAYWARD, R. S. A., WILSON, M. C., TUNIS, S. R., *et al* (1995) Users' guides to the medical literature, VIII. How to use clinical practice guidelines. *Journal of the American Medical Association*, **274**, 570–574.

PALMER, C. (1996) Clinical practice guidelines: the priorities. *Psychiatric Bulletin*, **20**, 40–42.

SIMON GILBODY
High Royds Hospital, Menston LS29 6AQ

Diversion of mentally disordered offenders: a step too far?

Sir: There is reluctance on the part of the police and the Crown Prosecution Service to prosecute mentally disordered individuals who have committed offences. This is frequent when the offender is living in the community but most marked when the offender is in hospital and particularly when detained under the Mental Health Act.

Where there is a causal relationship between mental illness and an offence, diversion into psychiatric treatment is more just and humane than imprisonment. Regretfully, the overwhelming majority of offences committed by mentally ill persons are not causally related to the illness; they instead represent an epiphenomenon related to the offender's perception that diagnosis of mental illness indemnifies him or her against punitive judicial action.

The Clunis report highlighted the failure of the Metropolitan Police to charge Clunis with repeated offences that he committed; as a result, his record of convictions bore no entries for offences of violence despite a very long track record of violent behaviour. He was instead diverted into the psychiatric system without any record of his dangerousness.

Supervision registers will not solve this problem since they blur the distinction between danger to others and to self, and without a centralised online system available to every police station and psychiatrist, information forewarning of dangerous behaviour is generally unavailable until too late.

Effective rehabilitation strategies must make use of rewards and punishments: if mentally ill patients know that they can offend in a way that their 'healthy' counterparts cannot, without attracting punitive measures, then they will continue to offend, particularly when significant degrees of personality disorder are present.

Care in the community is all very well for the majority of those with severe and enduring mental illness but it must be backed up by facilities for those who repeatedly offend. A particular problem is posed by those who offend while in mental states which are self-induced – patients with mental illness who abuse illicit drugs or who fail to take their prescribed treatment, and it may be appropriate for long-term institutional care to be provided for such individuals.

Mentally disordered offenders are still offenders and should be charged and convicted. Diversion should take place with regard to the penal rather than the legal system.

D. R. DAVIES
Avalon NHS Trust, Rydon House, Cheddon Road, Taunton TA2 7AZ

Care programme approach in the community

Sir: Chris Gilleard gave a comprehensive description of the intertwined processes of care programme implementation and audit in two London Boroughs (*Psychiatric Bulletin*, December 1995, **19**, 750–752). The audit looked at both percentages of psychiatric patients who had care programmes and various quality standards to do with the care programme process itself. In Bristol we performed a retrospective case notes audit focusing on in-patients from units in two Health Care Trusts. This showed a similar trend of increasing rates of care programming for patients discharged in May 1995 compared to the two previous years. Results from the third Health Care Trust in Bristol were also available for May 1995 and with the combined data we were able to address the question 'which patients are not getting care programming?'

In all three Trusts, patients admitted for longer periods were more likely to have a care programme and those in hospital for less than one month, the least likely. With respect to age there was no clear relationship other than that the over 65 years of age group fared best. Those patients with organic diagnosis (F00–F09) were most likely