which may involve a healthy modesty and ability to share and even to let go.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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Two heads are better than one

An article starting with a quote from Sherlock Holmes always grabs my attention and Burns' article is no exception.[1]

We made the in-patient/out-patient split in Greenwich in 2006, which resulted in my relinquishing my in-patient work. Initially, I was not at all keen on the idea, for the very reasons laid out by Burns. As time has gone on, however, I have completely changed my mind.

The main positive feature for me is that one has the benefit of a very experienced consultant colleague reviewing the case, including the diagnosis and the management plan. When there is agreement, I feel reassured and move on with improved confidence. When there is a difference of views, I have the opportunity to examine what is being said and to learn from it.

I thought many patients would hate it, but in the 4 years that have elapsed since the change, only one or two have complained to me about it. It has been a helpful change.

1 Burns T. The dog that failed to bark. *Psychiatrist* 2010; **34**: 361–3.

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Towards integrated care in Europe

The split responsibility for in-patient and out-patient care is one of the most serious problems facing mental healthcare in Europe. It is a major obstacle in the continuity of care, particularly with severely mentally ill patients.

I have been involved in mental health services research for 30 years. During that time, I have observed increasing efforts to overcome this split responsibility. There are several ongoing evaluations of 'integrated care' all over Europe, which have been developed to overcome this divide. Britain has always set a good example in integrated care and it would be a great pity if the NHS were to abandon this well-accredited approach.

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Do we stand by the values upon which the College was founded?

The association between the non-restraint movement and the formation of the Royal College of Psychiatrists has never been formally acknowledged in either current or past literature. This movement was a significant step in the humane treatment of patients within the psychiatric system and a focus point for the development of other forms of treatment for aggression and mental disorder.

The movement originated in York Asylum in the early 1800s, started by Pinel and Tuke, and was then taken up by Lincoln Asylum's lead physician, Edward Charlesworth. From 1828, also the time of Parliament attempts at passing legislation to improve monitoring of madhouses, Lincoln Asylum had gradually reduced the use of mechanical restraints, until their complete abolition in 1838.[1] By 1839, interest had been generated, and Dr John Connolly visited from Hanwell Asylum in Middlesex. After witnessing Lincoln's progress, Connolly set about abolishing the use of mechanical restraints in Hanwell.[2] By 1841, Lincoln was not the only asylum to abolish the use of restraints: Hanwell, Montrose and Northampton (now St Andrews Hospital) had joined the non-restraint movement.[3]

In early 1841, Samuel Hitch, resident superintendent of the Gloucestershire General Lunatic Asylum, proposed the establishing of an association of 'Medical Gentlemen connected with Lunatic Asylums'.[4] He sent a circular to 88 resident medical superintendents and visiting physicians in 44 asylums in June 1841, requesting their participation in his proposed association. The first annual meeting of the Association of Medical Officers of Asylums and Hospitals for the Insane took place on 4 November 1841, where it was announced: 'The members here present have the greatest satisfaction in recording their appreciation of, and in proposing a vote of thanks to those gentlemen who are now engaged in endeavouring to abolish [mechanical restraint] in all cases.'[4]

This association later became the Royal College of Psychiatrists (1971) and this clear statement supporting the abolishment of the use of mechanical restraints heralded a new era.

The use of mechanical restraints remains current given the specific references in both the Mental Health Act Code of Practice and National Institute for Health and Clinical Excellence guidance, despite the extremely limited evidence base. It is helpful to be reminded that the College began with such benevolent principles: challenging the *status quo* and striving for the very best for our patients.

1 Walk A. Lincoln and non-restraint. *Br J Psychiatry* 1970; **117**: 481–95.

2 Suzuki A. The politics and ideology of non-restraint: the case of the Hanwell Asylum. *Med Hist* 1995; **39**: 1–17.

3 Smith L. 'The Great Experiment': the place of Lincoln in the history of psychiatry. *Lincolnshire Hist Archaeol* 1995; **30**: 55–62.

4 Bewley T. *Madness to Mental Illness: A History of the Royal College of Psychiatrists*. RCPsych Publications, 2008.

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Defining coercion

To define coercion as a subjective response to a particular intervention that is an unfortunate but necessary part of the care of people with psychiatric illness is astonishing![1] This Orwellian definition cannot go unchallenged.

Dictionaries define coercion as: 'the act of compelling by force of authority; compulsion'; 'the act, process, or power of coercing . . . arm-twisting, force, compulsion, constraint, duress, pressure'; 'power based on the threat or use of force'; and so forth.

'If slavery is not wrong, nothing is wrong', declared Abraham Lincoln. Slavery is depriving a person of liberty because of who he is, not because of what he does or has done. If psychiatric slavery – involuntary mental hospitalisation – is not wrong, nothing is wrong.[2]

1 Newton-Howes G. Coercion in psychiatric care: where are we now, what do we know, where do we go? *Psychiatrist* 2010; **34**: 217–20.

2 Szasz T. *Coercion as Cure: A Critical History of Psychiatry*. Transaction Publishers, 2007.

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Why are psychosocial assessments following self-harm not completed?

Mullins *et al*'s study of accident and emergency (A&E) presentations following self-harm added to the evidence for poor uptake of psychosocial assessments in the initial management of self-harm.[1] Of particular concern was the finding that single men under 45 represented 39% of those not assessed. Although suicide rates among men in the UK fell between 1992 and 2007, the 2008 figures show a rise to 17.7 per 100 000, with highest rates seen in men aged 15–44.[2] A young man's presentation to A&E following self-harm is a valuable opportunity to offer interventions which reduce his risk of repetition. The paradox is that with many of these opportunities being missed researchers cannot evaluate the effectiveness of interventions to reduce repetition in this group.

Those who discharge themselves from A&E before completed assessment are 3 times more likely to repeat self-harm in the following year than those who are assessed.[3] It is possible that impulsive personality traits are more heavily implicated than the lack of an assessment, but we need to know more about this group's behavioural characteristics so that we can learn how to engage them as soon as they present. From the Mullins *et al* study it is not clear whether patient factors or staff factors were more influential in determining completion of a psychosocial assessment. The National Institute for Health and Clinical Excellence (NICE) recommends that patients who self-harm are 'treated with the same care, respect and dignity as other patients',[4] and reforms to medical and nursing training in some areas of the UK have managed to achieve cultural change.[5] This is crucial because a humiliating or uncomfortable experience in A&E is likely to dissuade a patient from presenting should they self-harm again, and in cases of overdose this may increase mortality risk.

It is striking that of the 341 patients in Mullins *et al*'s study who did not receive a psychosocial assessment, 141 (41%) subsequently presented within the year of data collection having self-harmed, of whom 74 (52%) slipped through the net a second time. We are unclear of the demographic characteristics of this subgroup, or whether there was a tendency for these individuals to leave A&E at the same stage in the referral process. However, if a study of this kind was repeated across a larger geographical area, it could be sufficiently powered to reveal valuable predictors which would help A&E staff decide which patients to fast-track.

Finally, NICE recommendations on the communication of findings after self-harm assessments require auditing in future similar studies. A patient's general practitioner (GP) or community mental health team may remain completely unaware of their presentation to A&E following self-harm unless a copy of the assessment is communicated to the relevant professionals. Even if the full psychosocial assessment was not performed, an outline of the presenting complaint would be of value. Armed with this information, a GP or key worker would be able to discern any patterns emerging in self-harm presentations, sometimes to many different hospitals, and would be in a unique position to manage apparent escalations in risk.

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2 Office for National Statistics. *Suicides: UK Suicides Increase in 2008*. ONS, 2010.

3 Crawford MJ, Wessely S. Does initial management affect the rate of repetition of deliberate self harm? Cohort study. *BMJ* 1998; **317**: 985.

4 National Institute for Health and Clinical Excellence. *Self-Harm: The Short Term Physical and Psychological Management and Secondary Prevention of Self Harm in Primary and Secondary Care. Clinical Guidelines 16*. NICE, 2004.

5 Pitman A, Tyrer P. Implementing clinical guidelines for self-harm – highlighting key issues arising from the NICE guideline for self-harm. *Psychol Psychother Theory Res Practice*. 2008; **81**: 377–97 (Special Issue: Implementing Clinical Guidelines in Everyday Practice).

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Let's target screening more effectively

I was very interested in the paper by Gumber *et al*,[1] which examined the monitoring of metabolic side-effects of anti-psychotics in patients with schizophrenia. I commend them for their attempts to follow guidance for this monitoring and I agree that metabolic side-effects are important considerations for this group of patients. However, my critical review of the evidence of risk to patients with mental illness does not support the use of such widespread monitoring.

I will use the example of lipid monitoring to illustrate this. A large general practice study in the UK[2] found that the relative risk of death from cardiovascular disease in people with mental illness when compared with controls was highest in younger people and reduced with age to a point that was not statistically significant in people over the age of 75. The authors of that study claim that the three-fold increase in deaths for people under the age of 50 is the most worrying. This may be so, but the finding is worthy of closer scrutiny, especially when the implications for screening are being considered. In fact, the absolute risk of death from coronary heart disease in people with mental illness aged 18–49 was 0.1% over a median follow-up period of 4.7 years.

European guidelines for prevention of heart disease[3] recommend monitoring of lipids only when the 10-year risk reaches 5% or more. It would seem difficult therefore to justify routine monitoring of mentally ill people aged 18–49.