phase was not pushing the cost of the DLP above the cost of standard services.

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Psychiatric training in the Netherlands

Sir: Dr Hall and Dr Robertson (*Psychiatric Bulletin*, **20**, 482) have accurately depicted training experience in the Netherlands. Their report, however, contains one important mistake. The MRCPsych is not recognised as a postgraduate specialist qualification in the Netherlands, nor in any other EU country. Recognition of specialist status was, and is, entirely contingent on obtaining the certificate of Completion of Specialist Training, issued by the UK General Medical Council in accordance with articles 2–7 of EU Directive No 75/363 of 16 June, 1975 (the Second Medical Directive). Aquisition of this certificate certainly does not represent a 'fast lane', as it is issued only after a sufficient amount of time of clinical experience at UK Senior Registrar level after passing the MRCPsych. Currently, a Dutch doctor in the UK will have to spend at least six years in training to obtain the CCST (18 months more than in the Netherlands): a minimum of three years in order to obtain the MRCPsych, and three more as a senior registrar.

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Second medical recommendations and good practice

Sir: The Code of Practice states "Other than in exceptional circumstances, the second medical recommendation should be provided by a doctor with previous acquaintance of the patient". In the absence of such an individual then this recommendation should be made by an "approved" doctor. What constitutes "previous acquaintance"? To what degree should pragmatism justify deviation from clear guidelines?

GPs are increasingly utilising Deputising Services to provide out of hours cover for their patients. Thus requests for emergency Mental Health Act (MHA) assessments are frequently being made by deputising doctors who will almost certainly have never encountered the patient before and most probably will not have had access to their GP notes. Should such doctors be providing second recommendations for admission on the tenuous grounds that they have "previous acquaintance" by merit of interviewing the patient perhaps an hour before the "approved" doctor comes to undertake an assessment? Similar dilemmas confront GPs who may never have met a patient on their list. Can perusal of previous medical notes achieve "acquaintance"?

I have encountered varied opinions among psychiatrists, GPs and social workers regarding these issues, resulting in different actions in comparable clinical situations. If one adheres rigidly to the Code of Practice then an increase in Section 12 approved doctors, particularly GPs available out of hours, would be desirable. The increased utilisation of Section 4 might be considered an alternative. Davies (*Psychiatric Bulletin*, August 1996, **20**; 502) has suggested other reasons why Section 4 may often be more appropriate than Section 2. Psychiatrists will be asked by GPs to provide guidance regarding the MHA and thus we should lead the debate as to what is contemporary good practice.

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Section 4 or 5(2)

Sir: Davies (*Psychiatric Bulletin*, August 1996, **20**, 502) rightly claims that the Code of Practice is being interpreted as pressing us to implement Section 2 rather than Section 4, use of the latter being seen by Purchasers as a sign of poor practice. However, interpretation is subjective and can lead to confusion. The Code (8.9) also says "Section 5(2) should only be invoked if the use of sections 2, 3 and 4 is not practicable or safe . . .". For in-patients section 4 can be both practicable and safe, so should it be used instead of 5(2) as the Code advises? We all realise that the, usually helpful, Code should not be so interpreted – this paragraph may soon be changed. The issue is relevant, our recent audit showed that 50% of our Section 5(2)s, could have been Section 4s since an approved social worker (ASW) was on site when the doctor made the 5(2) recommendation. "The attendance of senior psychiatrists at unearthly hours of the night" cannot be demanded by Purchasing authorities and social services. What is required is a rota staffed by Section 12 doctors who do not have to work the next day. This applies to ASWs. Finally, has the Purchaser arranged a service by senior psychiatrists to the police station?

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High dose antipsychotic prescribing

Sir: Chaplin & McGuigan (*Psychiatric Bulletin*, August 1996, **20**, 452–454) address the issue of

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clinicians' resistances to implementation of research findings regarding antipsychotic prescribing. This is not new and similar findings were reported throughout the 1980s including a follow-up survey demonstrating lack of change in practice over the time during which a number of such studies were published (Clark & Holden, 1987). Nonetheless polypharmacy and prescription of high dosage still persist across the psychiatric specialities and age ranges (e.g. Lowe *et al*, 1996) despite evidence that clinical audit can be an effective vehicle of change of prescribing habits (Warner *et al*, 1995). Surely the implicit challenge that Chaplin & McGuigan lay down is that it may be our anxieties and "need to do something" when confronted by chronic illness or risk of harm to self or others that influence some of our treatment decisions more than our knowledge base. Education, provision of information and even audit acitivities will not produce change without an openness to examine not just our practices but also our underlying motivations and feelings.

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Highly specialised services

Sir: Recent articles on this topic (*Psychiatric Bulletin*, November 1995, **19**, 657–659; March 1996, **20**, 129–130) require further comments. First, I add two such services not listed:

(i) Gender identity disorders
(ii) Psychosurgery

I have been able, with considerable cooperation from colleagues in a variety of fields, to establish services on a regional basis for both these services; they have been well used in terms of referral from colleagues.

The first of the *Bulletin* articles raises the topic of the future of specialised services once the originator retires. As the date for my retirement hoves into sight the question of the future for these services is now under discussion. Lack of experience of the work is likely to be a factor inhibiting potential applicants. My colleagues and I have recognised the importance of a long handover period during which a successor may observe and acquire the relevant knowledge in order to conduct the service in which he/she has a potential for interest. This fact must be observed if a special service is to continue.

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Suicide in the severely mentally ill

Sir: A retrospective review of suicide in in-patient units was initiated in the Northern Region, in view of the recent interest in suicide in the severely mentally ill, and revealed 24 suicides of in-patients of psychiatric units between 1991 and 1993, of which 22 cases were audited. Eight (36%) of the study population had a diagnosis of depression (ICD–10). Results indicated that five out of eight (63%) of this group committed suicide between the hours of 12 midnight and 6 am. If bipolar depressed patients were excluded from the depression group four out of five (80%) committed suicide between these times. This suggests that higher levels of observation are required for depressed patients in hospital in the early morning when staffing levels are normally at their lowest.

Half of all depressed patients were outside the hospital at the time of suicide. Two were on agreed leave and two were absent without leave. Similar findings were reported by the recently published *Confidential Inquiry into Homicides and Suicides by Mentally Ill People* (Royal College of Psychiatrists, 1996). This would indicate that greater vigilance has to be exercised in authorising leave in patients suffering from depression, particularly those who have, in the past, been considered to be a serious suicide risk. For example, one patient granted leave had made three previous attempts on her life by hanging, drowning and poisoning by car exhaust fumes.

Although suicide is a rare event and therefore the numbers of patients reviewed were only small, the audit does highlight a group of patients who appear to be at greater risk. The degree of supervision on discharge from a ward is critical and should involve other agencies outside the hospital such as GPs, CPNs and also the relatives. It is recommended that future audit programmes assess the effectiveness of leave arrangements prior to the patient being granted any home leave, especially for depressed or previously suicidal patients.

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