the proposed treatment. For this to happen, the patient needs to be given the relevant information, to be able to understand and weight it and to state his or her choice. The patient must have the 'capacity' to do this and not be under duress.

White's patient had been given the information and the fact that he was able to withdraw his consent suggests he was not under duress. My concern is whether or not the patient's capacity to give consent was compromised by his illness. There are legal tests of capacity but these are not useful in clinical practice. A further dilemma is posed as, while wanting to respect the autonomy of patients, the alternatives available with respect to consent are perplexing. Many people with serious long-term mental illness cannot give informed consent but treating each under section 3 of the Mental Health Act would swamp the system, might mar therapeutic relationships and is often resisted by other staff.

C. BRABBINS, *Whiston Hospital, Prescot, Merseyside L35 5DR*

Antidepressant prescribing in New Zealand

Sir: I read with interest Dr Thompson's paper on antidepressant prescribing (*Psychiatric Bulletin*, August 1994, **18**, 461–462). Having worked in the same community team and at the local in-patient unit, I feel the article brought up an interesting point relating to the consultation fee that New Zealand residents pay to see their GP (but not to see a mental health professional).

This fee caused problems in the management of people with mental ill health. People developed a reluctance to visit their GP (often voiced in clinic) with a resultant pressure on GPs to have longer intervals between consultations and therefore having to write prescriptions to cover longer periods. This created problems, especially where there was a suicide risk as the patient could have a larger quantity of medication in his or her possession. There may therefore have been a reluctance to prescribe a therapeutic dose and to opt for a sub-therapeutic prescription. This perversely may leave patients at greater risk as their depression remains untreated. It was also my impression that referrals present earlier in the course of illness which may be a result of the fee. Finally, there was a lack of shared care between the GP and mental health team as a consequence of the reluctance of patients to see their GP, because of the financial burden. This may have a secondary effect of de-skilling the GP.

KEITH R. LINSLEY, *St George's Hospital, Morpeth, Northumberland NE61 2NU*

Training in a home treatment team

Sir: Smyth & Bracken (*Psychiatric Bulletin*, July 1994, **18**, 408–409) describe their training experience in a home treatment team. Having worked as a registrar with the same team I share many of the experiences they describe. I would like to add a few further observations.

Smyth & Bracken describe how "working without the apparent security of hospital wards initially provoked anxiety." My previous working experience as a junior doctor in various hospital settings had not been free from anxiety. There were worries and uncertainties about patient and staff well-being and safety but more noticeable to me were anxieties provoked by the way 'hospital systems' operate. The need for control and request that the patient should fit into hospital routine are central to treatment within institutions. Behaviour that is unacceptable within these regimes will frequently be interpreted as part of mental illness and result in the increase of control in various forms. My anxieties were related to the fact that I often felt unsure whether 'mental illness' or the 'social context' were the source of a particular presentation.

My working experience with a home treatment team has not given me an altogether different picture of psychiatric illness. Psychotic experiences seen similar whether at home or in hospital. I was, however, struck by the different kinds of relationship that seem possible between patients in their own home environment and the professionals offering support. As a result I have started to look at psychiatric illness in a different light and I have become more aware of the extent to which 'the illness' is a social construct rather than a clear medical entity. This broader view of psychiatric illness has in my case led to a very positive and fulfilling working experience.

IRENE LAMPERT, *North Birmingham Mental Health Trust, East Sector, Birmingham B10 9JH*

Cardiopulmonary resuscitation

Sir: The study by McNaughton, Hall & Stark (*Psychiatric Bulletin*, July 1994, **18**, 403–404), revealing the poor technical proficiency of junior doctors in cardiopulmonary resuscitation (CPR), confirms the fears of many junior doctors who are often the only medical cover for a large number of in-patients. However, the recommendation of the authors that junior doctors receive regular refresher courses in cardio-pulmonary resuscitation is insufficient.

Many psychiatric hospitals are on extremely large sites, while many on-call duties involve covering a number of different sites. It is therefore essential that all clinical staff, especially

https://doi.org/10.1192/pb.18.11.703-b Published online by Cambridge University Press

nursing staff, are proficient at CPR. Any planning of training courses must involve the staff who are in most contact with the patient and this is often the nurses. However proficient a doctor is at CPR it is useless if the patient is not oxygenated effectively until he or she arrives.

D.I. WILLIAMS, *East Glamorgan Hospital, Church Village, Pontypridd, Mid Glamorgan*

Psychiatric emergencies

Sir: A working party of the Collegiate Trainees Committee (*Psychiatric Bulletin*, June 1994, **18**, 357–359) drew attention to the management of violence as one of a number of areas of psychiatric training in need of improvement. Others included community, liaison and forensic specialities. Emergency psychiatry may represent the richest source of experience in all these areas and there currently exists an opportunity to change the profile of on-call activities dramatically: instead of having to be resident in a psychiatric hospital, the SHO/registrar can now work in the community while covering the general wards and casualty.

This should not disadvantage the psychiatric wards of a trust. In a recent survey of the out of hours activities of resident junior medical staff at the 235 (mostly acute) bedded Hollymoor Hospital, nearly a third of calls to the wards were for routine work. Of the problems that arose out of hours, 30% did not require a visit to the wards; of those that did, 43% involved some form of administrative duty that could have waited. The total time that a psychiatrist spent on clear-cut emergencies was four hours and 40 minutes. Roughly two thirds of this time was spent dealing with medical or surgical emergencies.

An on-site psychiatrist has a limited role. Community and liaison activities would broaden the experience of being on call and partly rectify the reported deficiencies. Close supervision of an inexperienced but mobile SHO/registrar by a senior would provide unique opportunities for training. In the early weeks, the supervisor could be 'shadowed' by the trainee, independence developing once a suitable amount of experience had been accumulated, perhaps being documented in a logbook and overseen by the clinical tutor.

NEIL DEUCHAR, *Registrar, The Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham, B15 2QZ and* KEVIN LANE, *Medical Audit Assistant for Psychiatry, Solihull District Health Authority, Hollymoor Hospital, Birmingham, B31 5EX*

Fund-holding general practice and old age psychiatry

Sir: I read Fear & Cattell's paper on fund-holding general practices and old age psychiatry with considerable interest. (*Psychiatric Bulletin*, May 1994, **18**, 263–265). We are, of course, all heading down this road to either heaven or perdition. Some aspects are not commented upon by the authors.

First, the massive increase in domiciliary consultations from non-fund-holders between April 1991/92 and April 1992/93, yet out-patient referrals for non-fund-holders remain the same as do referrals to community teams by general practitioners, while community team referrals by other agencies fall. However, for fund-holders the opposite is the case. Referrals by domiciliary consultation and community team referrals by GPs both fall but community team referrals by other agencies interestingly increase by ten.

Are GPs trying to minimise their costs of psychogeriatric patients by reducing direct referrals to community team referrals or domiciliary consultations? Other agencies are increasing their referral rates for fund-holder patients. This would support the supposition that appropriate referrals by GPs to specialist services are increasing other (by the back door) referrals to the psychogeriatric team. Certainly, there is longstanding evidence that if psychogeriatric patients, particularly those with dementia, are not provided with services specifically to meet their requirements then they enter the health-care system by any loophole available to medical and orthopaedic wards, inappropriate and untimely placements in nursing homes, etc.

Psychogeriatrics as a speciality came into being to prevent this misuse of expensive alternative NHS resources by inappropriate placements.

Maybe we are travelling 'back to the future'.

R. M. PHILPOTT, *EMI Directorate, Sir Douglas Crawford Unit, Mossley Hill Hospital, Liverpool L18 8BU*

Career guidance for psychiatric trainees

Sir: We agree with Kehoe *et al* (*Psychiatric Bulletin*, March 1994, **18**, 161–163) that there are deficiencies both nationally and locally in career guidance for psychiatric trainees. A recent study surveyed 73 career psychiatric trainees at SHO and registrar level in Merseyside and had a response rate of 59% with 43 questionnaires being returned. It showed that only 43% had received advice about how to structure their career. This included advice on psychotherapy

https://doi.org/10.1192/pb.18.11.703-b Published online by Cambridge University Press