Correspondence

Less severe mental illness

Sir: Dr Lacey and Dr Caldicott are quite right (*Psychiatric Bulletin*, August 1996, **20**, 496). The term 'less severe mental illness' has no place in our vocabulary; likewise the term 'minor psychiatric disorder'. 'Minor psychiatric disorder' usually refers to somatic or psychological symptoms of anxiety, mostly seen in general practice which, although unpleasant, are not in themselves seriously incapacitating. However, the cause of such symptoms is usually a major personal conflict, often accompanied by great distress in the family and if these patients are to be helped, they require a great deal of time and skilled work, much more than is usually required for the management of schizophrenia. As well as the ill-effects mentioned by Dr Lacey and Dr Caldicott, the use of terms like 'minor' or 'less severe' leads managers to think that no special skills need to be provided.

SAMUEL I. COHEN, *Emeritus Professor of Psychiatry, University of London*

The culture of enquiry

Sir: A disturbing experience for most psychiatrists has been to hear or read about the deliberations of the latest committee of enquiry through the media. These eponymous reports are often referred to subsequently, in the presumption that their contents are widely known. Unfortunately, this is often not the case. As senior registrars working in the NHS, it might reasonably be assumed that we would be well informed about these. In fact, a common experience among us has been to come upon these informally, if at all. This is clearly not acceptable and means that valuable lessons are not necessarily being disseminated. Another dimension is that these reports and their recommendations have taken on a quasi-legal status and as such, ignorance of their contents is unacceptable.

We suggest that the Royal College of Psychiatrists is ideally placed to ensure that systematic dissemination of these deliberations takes place. One suggestion is that all of these reports should be reviewed in the *Psychiatric Bulletin*. A precedent for this exists by editorial comment on the Christopher Clunis enquiry in the *Bulletin* by Coid (1994). Other possibilities include mandating clinical directors of Trusts or tutors to ensure appropriate circulation of reports or at least access to them. There are many benefits from the revolution in the NHS and the delivery of mental health services but one of the biggest dangers of decentralisation and deinstitutionalisation is fragmentation. Whatever solution is found, it is imperative that clinicians are aware of the contents of reports and we urge the College to act on this.

COID, J. (1994) The Christopher Clunis enquiry. *Psychiatric Bulletin*, **18**, 449–452.

JOHN COONEY, *Chairman SR Group, St Bartholomew's Scheme*; JAMES WARNER, *Lecturer, Royal Free Scheme*; JONATHAN HILLMAN, *Chairman SR Group, Royal Free Scheme*; FARIDA YOUSAF, *Chairman SR Group, St George's Scheme*; PAUL DEWSNAP, *Chairman SR Group, Charing Cross & Westminster Scheme*; FRANK KELLY, *Chairman SR Group, The Maudsley Scheme*; KATRIN EDELMAN, *Chairman SR Group, Royal London Scheme*; HUW THOMAS, *Chairman SR Group, UMDS*

The first 12 months of a community support bed unit

Sir: Philip Thomas and colleagues (*Psychiatric Bulletin*, August 1996, **20**, 455–458) rightly point to the need to distinguish between specially-funded 'demonstration projects' and standard services. They suggest that the short-term outcomes of the Maudsley Daily Living Programme (DLP) were possible because of the special status of the DLP, and they argue that the lack of outcome differential in the medium term (at 45 months) was due to the service ceasing to be an intensive 'experimental' service.

The DLP may have been able to bring more intensive staff resources to bear on the psychiatric problems presented by patients than is usually the case in community care, but it was still substantially cheaper in the short term and no more expensive in the medium term than the hospital-based standard services which it sought to replace (in-patient stay followed by out-patient support).

The lack of cost effectiveness for the DLP in the fourth year can probably be attributed to two things. First, DLP staff ceased to have control over in-patient admissions. Second, there was staff demoralisation, linked to the first issue, but perhaps also a consequence of moving from high-profile experimental service to standard, 'mainstream' service. However, it must be stressed that the intensity of staffing in the early

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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