neighbours, but adopted a description of their speciality which had an upbeat first and neutral second term (genito- and urinary, respectively). Sometimes this was cleverly reinforced by a move from poor premises outside the walls of hospitals to proper clinics within. Clear messages about the dangers of the conditions and their susceptibility to treatment was an issue, with informed guidance, for central and local health service organisations.

Some of those within psychiatry seem intent on the opposite path.

Is it possible that in psychiatry we have neglected the importance of symbolism, both to our patients and ourselves, in supporting the work we do? Sectorisation, 'community' trusts, the spectre of 'mental health' commissioning authorities, and professors of 'social' and 'community' psychiatry all stigmatise psychiatry as a 'different' medical speciality; we have much to do.

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Primary care-based mental health promotion drop-in clinic

Sir: It is difficult to agree with the conclusions of Gilleard & Lobo (*Psychiatric Bulletin*, September 1998, **22**, 559–562) that "there is a viable role for mental health promotion" in the form of a drop-in clinic based in primary care. Only 55 contacts occurred in 11 months at a twice weekly clinic run by two members of the mental health team. This represents around one patient seen for every 10 hours of professional time, which seems a rather expensive way of distributing information leaflets while informing patients and surgery staff about relevant local non-NHS services. Most general practitioners would consider that a poster in the waiting room would achieve a similar objective and capture a much wider audience at a fraction of the cost.

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Medical reports for mental health review tribunals

Sir: Ismail *et al* (*Psychiatric Bulletin*, October 1998, **22**, 615–618) found at the Maudsley Hospital that three-quarters of Section 3 tribunal reports studied had failed to address completely the statutory criteria for continuing detention, without that failure having affected the outcome of hearings. They advocate replication of their study elsewhere and better training for report writing.

The roles of doctors in mental health review tribunals have been surveyed by Langley (1990) and Woolf (1991). It will always be an essential routine at tribunal hearings to address the statutory criteria orally during the questioning of the doctor who attends to represent the health authority. This is required to establish whether the conclusions of the report need to be amended on the day of the hearing, even for the minority of Section 3 cases in which medical reports are 'complete'.

Of far greater concern for tribunal members, patients' representatives and their independent experts, and for Mental Health Act administrators, is the equally common failure of responsible medical officers to deliver Section 3 reports within the prescribed three weeks (over 70% at some hospitals).

There may be several good reasons why this happens, including wide misunderstanding of the requirement and its importance. Delays are often justified on the basis that the patient's mental state might change and that it remains to be decided whether the further detention will ultimately be defended. Woolf (1998) has discussed hearings abandoned, often very late and, sometimes inexplicably, without medical reports having been submitted. Early, concise reports, focused upon the key issues, and later supplemented by updates as necessary, make for smoother and better tribunal hearings.

LANGLEY, G. E. (1990) The RMO and mental health review tribunals. *Psychiatric Bulletin*, **14**, 336–337.

WOOLF, P. G. (1988) Abortive hearings. *MHRT Members' News Sheet*, **2**, 8.

— (1991) The role of the doctor in the mental health review tribunal. *Psychiatric Bulletin*, **15**, 407–409.

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Use of placebo

Sir: There are only a few articles published on the use of placebo, either for diagnostic or treatment purposes; one notable and helpful example being Miller (1988).

I tend to use placebo sometimes for diagnostic purposes but more often as an adjunct in the treatment of anxiety, mild depression and insomnia. Except in one case its use was limited to oral 'medication'. My use of placebo was hotly challenged by visiting commissioners who considered it unlawful. After recent correspondence, the Chief Executive of the Mental Health Act Commission replied following discussion with

the Commission's Legal and Ethical Special Interest Group. He stated that though legal authority for the use of placebo is unclear until tested in court, general opinion within the Commission is that the authority to administer placebo could be provided by Section 63 of the Mental Health Act. As placebo is an inert substance it is not considered to fall within the definition of medication and so is outside the provisions of Section 58 of the Act.

Though this statement is helpful in some degree in resolving the issue with visiting commissioners, legal and ethical considerations need to be addressed and it is likely that Ashworth Hospital will formulate a protocol for the use of placebo. My intention in writing is two-fold. First to bring the Commission's view to the attention of psychiatrists who may be facing similar difficulty and, second, to enquire whether others have encountered similar problems and have formulated policy/procedure for the use of placebo.

MILLER, R. G. (1988) The use of placebo trials as part of a forensic assessment. *Journal of Psychiatry and Law*, Summer, 217–232.

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Psychiatric training and the Calman reforms

Sir: We were interested to read the survey by McCallum *et al* (*Psychiatric Bulletin*, October 1998, **22**, 635–638) concerning the changes to the senior house officer grade brought about by the Calman report. We were surprised, however, at the continued assertion that there have been only minimal changes to post-membership trainees. Infact there are similar effects on the new specialist registrar (SpR) grade in terms of status, financial reward and training arrangements.

In other specialties the SpR grade is an amalgam of registrars and senior registrars, and thus the experience of the individual trainees will vary greatly. The use of the same term in psychiatry, where it simply replaced the senior registrar grade, leads to confusion and in particular an under-recognition of seniority and experience.

Regarding financial reward, the SpR pay scale represents a merger of the registrar and senior registrar scales, leading to financial disadvantage compared with senior registrars. In addition, in comparison to our privileged predecessors SpRs are required to attain consultant posts within six months of award of Certificate of Completion of Specialist Training. This reduces significantly our ability to be both flexible and to achieve a comprehensive, broad-based training. While it seems that trainees at all levels express reservations about the Calman changes, these reservations would be acceptable if they lead to improved training.

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Improving trainees' knowledge of higher specialist training requirements

Sir: Having recently been both a Royal College of Psychiatrists Collegiate Trainees' Committee representative on a higher training scheme approval visit and an interviewee during an approval visit to my own scheme, I have developed a greater understanding of the College requirements for training and criteria for awarding Certificates of Completion of Specialist Training.

However, having this knowledge three years ago at the beginning of my senior registrar rotation would have been more useful and helped me to identify and address any deviations from the requirements before now. My experience of interviewing trainees on the approval visit suggests I am not the only trainee to be unsure of the College training requirements. Trainees do have a responsibility towards the quality of their education and therefore need to be well informed about what they can expect from their training. The College Higher Specialist Training Committee (HSTC) has produced a handbook which details these requirements which currently costs £7.50. The HSTC should consider helping to ensure wide distribution of this document by providing it free of charge to all higher trainees at the start of their rotations and perhaps by complementing it with a Higher Specialist Trainees Charter, summarising the expectations of training for both trainees and trainers. Although charters have developed a bad reputation in the health service, education and training charters have been successfully introduced for health service staff by bodies such as the Open University.

I would recommend the valuable experience of being a Collegiate Trainees Committee representative on an approval visit to all trainees, and that they obtain a copy of the HSTC handbook.

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Higher Specialist Training Handbook* (Occasional Paper OP43). London: Royal College of Psychiatrists.

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