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correspondence

Dangerous severe personality disorder – not a new problem

Sir: People with dangerous severe personality disorder have long been recognised by psychiatrists to be beyond the remit of the psychiatric services. This point is nicely illustrated by a case summary of a patient admitted in 1838 to the newly opened Northampton Asylum (now St Andrew's Hospital).

A 26-year-old labourer said to be suffering from 'insanity caused by intoxication and sleeping at night in the open' was transferred to the asylum from Oakham Gaol. He had a history of violent assault and in prison had been kept heavily ironed. In hospital he continued to exhibit episodic violence. Thomas Prichard, the medical superintendent, wrote 'he went on very well until yesterday when he broke out into open mutiny. He is a reckless profligate'. He was not placed in mechanical restraints, as this was against the philosophy of the hospital, but solitary confinement and low rations were used. The patient exhibited no signs of 'insanity' throughout his stay. A month after admission Dr Prichard wrote 'I do not consider him a proper inmate for an establishment like ours. I very much doubt that we possess the power of reclaiming him (by moral management) and firmly believe the treadwheel or cat o' nine tails would be found more efficacious'. Prichard applied to the hospital governors for permission to discharge the patient. This being granted, 6 weeks after admission he was sent home and nothing more was heard of him.

Today, under the Government's new Mental Health Bill, his fate might be very different.

Camilla Haw, Consultant Psychiatrist, St Andrew's Hospital, Northampton NN1 5DG

The suicide bomber: is it a psychiatric phenomenon?

Sir: Harvey Gordon's paper (*Psychiatric Bulletin*, August 2002, **26**, 285–287) was refreshing on a worrying topic. I enjoyed the wide academic references to drive home an unemotional and rational argument. I was reassured by the conclusion that there was no need to apply a psychiatric analysis to the phenomenon.

But at one point academic rigour was dropped and that bothers me. The last paragraph states 'religion can be a force for good'. Where's the evidence for that?

Peter Bruggen, Retired Consultant Psychiatrist, London

Assessing alcohol-intoxicated patients

Sir: We agree with McCaffery *et al* (*Psychiatric Bulletin*, September 2002, **26**, 332–334) that there is little consensus among psychiatrists as to how to manage intoxicated patients when they present. We collected questionnaire data from 164 health professionals – 53 psychiatrists, 56 psychiatric nurses and 55 third year medical students. Opinions on appropriate care protocols for intoxicated patients presenting at accident & emergency (A&E) departments or psychiatric emergency clinics were sought. Over a third of the psychiatrists (35%) and nurses (39%) were of the opinion that intoxicated patients should 'often/always' be sent away and asked to return when sober and almost half of the nurses (44%) and the psychiatrists (44%) thought that an assessment should 'never/rarely' be attempted with an intoxicated patient. In contrast, 47% of the medical students were of the opinion that attempts to make an assessment should 'often/always' occur. Two-thirds of the psychiatrists (67%) and the medical students (68%) indicated that they thought intoxicated patients should 'often/always' be provided with a safe place in which to wait until sober (sobriety suite). Opinions among the nurses were broadly distributed, although very few (4%) indicated that this should 'never/rarely' be offered. Over half (55%) of the sample indicated that they did not think it possible to section an intoxicated patient under the Mental Health Act.

If the findings from our survey accurately reflect actual clinical practice, then intoxicated patients, some with suicidal ideation or other mental health problems, are being sent away without an assessment. This raises the question of who is responsible. Psychiatric cover in A&E departments is very variable: in some, but by no means all, teams of psychiatric liaison nurses staff A&E departments and emergency psychiatric clinics. Part of their role is to assist in the detection, assessment and management of alcohol dependent patients (Royal College of Physicians, 2001). Clearly there is ignorance over the use of the Mental Health Act, which can be used where there is a comorbid psychiatric disorder. Our findings support those of McCaffery *et al* and suggest a need for care protocols for when intoxicated patients present. We agree that there is a need for greater clarity on the management of such patients at both the local and national level.

ROYAL COLLEGE OF PHYSICIANS (2001) *Alcohol. Can the NHS afford it? Recommendations for a Coherent Alcohol Strategy for Hospital*. London: Royal College of Physicians.

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Monitoring patients on lithium

Sir: I read the recent paper by Nicholson and Fitzmaurice (*Psychiatric Bulletin*, September 2002, **26**, 348–351) with interest. Their literature review preceded the publication of our fairly recent study (Eagles *et al*, 2000) that investigated lithium monitoring before and after the distribution of clinical practice guidelines in the north-east of Scotland. From our findings, I would wish to extend, and to mildly contest, some of the points made by Nicholson and Fitzmaurice.

With regard to specific points within the Lothian Guidelines, there are two points. Thyroid dysfunction occurs, commonly, more in women than in men and especially during the first 2 years of lithium treatment (Johnston & Eagles, 1999). It is probably logical, therefore, certainly in the early years of lithium treatment, to monitor thyroid function at

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6-monthly intervals. Second, I agree that there is no good evidence on which to base advised serum levels; Nicholson and Fitzmaurice selected 0.6–1.0 mmol/l, while we advise 0.5–1.0 mmol/l. It is important to note that, within this range, some patients may respond only at higher serum levels (Gelenberg *et al*, 1989).

As we did in north-east Scotland (Eagles *et al*, 2000), Nicholson and Fitzmaurice intend to audit the effect of circulating lithium monitoring guidelines in Lothian. We found that guidelines significantly improved the monitoring of renal and thyroid function. More importantly, however, standards of monitoring were poor before and after guideline distribution, and remained even poorer among patients who were no longer in contact with psychiatric services. We endorsed Cookson's (1997) conclusion that all patients on lithium should remain in contact with an experienced psychiatrist.

COOKSON, J. (1997) Lithium: balancing risks and benefits. *British Journal of Psychiatry*, **171**, 120–124.

EAGLES, J. M., MCCANN, I., MACLEOD, T. N. N., *et al* (2000) Lithium monitoring before and after the distribution of clinical practice guidelines. *Acta Psychiatrica Scandinavica*, **101**, 349–353.

GELENBERG, A. J., KANE, J. M., KELLER, M. B., *et al* (1989) Comparison of standard and low serum levels of lithium for maintenance treatment of bipolar disorder. *New England Journal of Medicine*, **321**, 1489–1493.

JOHNSTON, A. M. & EAGLES, J. M. (1999) Lithium-associated clinical hypothyroidism. Prevalence and risk factors. *British Journal of Psychiatry*, **175**, 336–339.

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the college

Thirty-first Annual Meeting

June 2002

The Thirty-first Annual Meeting of the College was held at the Cardiff International Arena, Cardiff, from 24 to 27 June 2002.

Business Meeting

The Business Meeting of the Royal College of Psychiatrists was held on Thursday 27 June 2002 and was Chaired by the President, Professor John Cox. It was attended by 103 members of the College.

The Minutes of the previous meeting held in London on 11 July 2001 were approved and signed.

The formal Report of the Treasurer and a summarised version of the Annual Accounts for 2000 were received and approved. The re-appointment of the auditors was approved. The new fees and subscription rates from 1 January 2003 were approved.

President's Report

Unlike last year's, this report will be short. Its brevity is not because of a lack of anything to report to members – the converse is the case – but because in my valedictory lecture I will look back as well as forward and because I have been working with a first rate and very committed team of Officers who will speak for themselves. Suffice to say that the adage 'in high speed times, if you blink something will have changed' is no longer only a useful metaphor, but almost a statement of fact.

There are several major strategy documents pending and no doubt they will be launched when least expected. Probably on a Friday evening or, as with the Mental Health Draft Bill, when the College meeting is taking place and when Wimbledon or the World Cup finals are diverting attention. If the wages of spin *are* death – the title of an interesting talk given at the meeting – then there must be a risk of terminal decline!

Let us hope, nevertheless, that there is a real consultation yet to take place that is evidence-based and attentive to the profound issues which affect our professionalism and the care of our patients. The Mental Health Draft Bill released very recently should, in my opinion, initiate a 'just struggle'.

The Senior House Officer (SHO) Modernisation Report, for which there is a leak of a leak, is also about to come into the public domain. It is likely to include a recommendation for a generic First SHO Year with a solid chance to change the postgraduate training of all doctors, to broaden their educational base and to include mental health and mental illness within such generic training. It will have profound implications to improve recruitment and retention of psychiatrists.

Thirdly, the new General Medical Council legislative changes have been announced, bringing in generally agreed new structures for revalidation and appraisal and, as far as the College is concerned, placing our novel and respected continuing professional development (CPD) programmes near to the centre.

The Government's proposal for the Medical Education Standards Board to replace the Specialist Training Authority and the consultation about legislative changes are likely to be published very shortly. The challenge to the Academy and to our College is to see that the influence of the College remains protected – in the best interests of the service provided to our patients, while recognising that there *is* a necessary dialogue with the NHS and Government with regard to the competencies of trained psychiatrists.

Finally, the amendments to the European Order are also imminent – amendments that may enable selected overseas- and UK-based doctors to enter the specialist register through a new route provided standards are upheld, and following any further 'top-up' training in the UK, if necessary.

The College is also, I believe, working on a consensus statement with regard to the Roles and Responsibilities for Psychiatrists, which arose out of earlier discussion about a Manifesto or a Consultants' Charter. A College statement of this sort, which could contain not only the legal framework within which we work but also the professional and ethical parameters as well as our values and priorities, could indeed be most helpful.

In the past year, the College has established a Board for International Affairs and an Ethnic Issues Committee, has increased its membership and has examined the largest number of candidates ever in its history. Now, I believe, the membership has voted with its feet by attending this meeting in Wales and so celebrating not just the closure of the Mind Odyssey but the excitement of the sharing of ideas and experiences with Members from across the world.

The College *is* very much alive, and has shown a remarkable ability this past year

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