his reluctance to prepare for and attend 'another "hopeless" Tribunal'.

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Use and abuse of Section 4/Section 2, Mental Health Act 1983

Dear Sirs

The Mental Health Act Commission and Code of Practice are quite specific that Section 4 should only be used in an emergency, and that Section 2 must be used, as far as possible, to admit patients who need such admission. This, of course, is reasonable and rational. However, the other side of the coin is that Section 2 could be mis-used and in certain circumstances Section 4 is appropriate and desirable rather than Section 2. This is valid in cases of "mental impairment" rather than "mental illness" as both conditions come under "mental disorder" in Mental Health Act 1983. This distinction is important as mental illness, particularly in its acute form, is amenable to chemotherapy and can be rapidly controlled, whereas mental impairment may or may not be amenable to medication, particularly the severe behaviour problems which would require time and different therapies, like behaviour therapy and counselling, to get effective control.

May I quote my experience in one situation where an approved Social Worker was insisting at about midnight that a patient was severely disturbed and that she must be admitted only on Section 2 and, therefore, the second doctor must visit to see the patient to implement this Section. I had to point out that this appears to be an emergency, that Section 4 is valid in this case as the second doctor is only 'on call', and not the regular doctor, and that as soon as the patient is admitted Section 4 will be reviewed and appropriate changes, and if necessary Section 2 implemented. The ASW was not happy with this explanation and found another second doctor to complete and implement the Section 2 requirement. The day after admission when I saw the patient I could find no evidence of mental illness or dangerousness on the part of the patient who was willing to stay in hospital voluntarily, and settled down well in the ward. Moreover, psychotropic medication was not necessary. I discovered the motive for admission was not a genuine emergency, but a social reason. If this patient had been admitted on Section 4, there would have been no reason to use Section 2. The legal means of admissions should be flexible enough for the doctors and ASWs to use the appropriate sections of the Mental Health Act.

The Mental Health Act Commission may like to comment about these occasional difficult situations which may lead to unnecessary friction between professional colleagues and detrimental patient care.

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Fitness to appeal

Dear Sirs

During a recent visit of Mental Health Act Commissioners, a Hospital Manager complained about the large number of appeals by patients against their detention under the Mental Health Act, and asked whether it would be possible to "... do something about reducing the number of appeals required to be heard." The Commissioners were sympathetic but unimpressed. All patients liable to be detained, they advised, had the right to appeal against their detention, even if it was obvious that they had no idea what they were doing.

In the past year, when I have asked patients why they had appealed against their detention, many of them were too psychotic to understand what the appeal was about, let alone put together a coherent reason for appealing – even on the day of the hearing! One Hospital Manager told me how, within minutes of several hearings, the Managers have asked for the patient to be returned immediately to the wards on account of their behaviour.

These experiences argue strongly for the introduction of 'fitness to appeal' criteria which would determine whether a patient is fit to appear before the Hospital Managers or a Mental Health Review Tribunal, and understands what the appeal is about, is able to instruct his legal advisers (if applicable), and can apsychotically challenge the evidence of the Responsible Medical Officer (RMO) or the Approved Social Worker. This would help to filter out – without prejudice to the patients' civil rights – those too disturbed to appear as well as those too psychotic to understand the transactions or marshal meaningful arguments against their detention.

I would suggest that the assessment of a patient's fitness to appeal should not be carried out by his RMO, since the RMO is an interested party. This could be work for an approved doctor not associated with the hospital (and not involved in the original

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detention) or another consultant at the hospital concerned, preferably one who does not share a ward with the patient's RMO.

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Breakaway techniques

DEAR SIRS

In response to the recent Report of the Collegiate Trainees' Committee Working Party on training of junior psychiatrists with respect to violent incidents (*Psychiatric Bulletin*, 1991, **15**, 243–246) we would like to share our experience at York.

Several measures have been implemented to help ensure safety, including written information regarding the management of potential violence on joining the training scheme, installation of emergency bells in consulting rooms and the formalised reporting of violent incidents. In addition, occasional guest lectures on the assessment and management of violent patients have been arranged.

The most useful measure, however, has been the Breakaway Techniques Course which we have arranged for trainee and senior medical staff. The breakaway techniques are designed to enable the professional working in isolation to safely remove themselves from the following form of attack: hair pulling, strangulation, grasping of clothing, 'bear hugs', and wrist grips.

We have attended one course comprising two half days so far. The course instructors were Home Office approved nursing colleagues who also teach control and restraint for the nursing staff. Originally, the junior doctors felt that training in control and restraint would be useful as often they are present at potentially dangerous situations on the ward. The junior doctors feel helpless while nursing colleagues are trying to restrain physically aggressive or violent patients on the Ward. However, due to the time commitment necessary for the Control and Restraint Course, the Breakaway Techniques Course was the best next alternative. However, we had difficulty in organising breakaway techniques due to the intransigence of senior nurse management with regard to releasing the instructors from their ward duties without reimbursement for their time. After protracted negotiation with the nursing hierarchy we were able to overcome this hurdle without any financial implications.

Once arranged, the course proved a success. Besides learning breakaway techniques, we gained confidence in our ability to deal with the potentially difficult situation and believe that this confidence in itself may prevent 'potential' developing into 'actual'.

It is planned to repeat the course six-monthly so that the new trainees joining the scheme will benefit early in their training and for others it will be a 'refresher'. If the number of medical staff is too small, it may be possible in future for them to join the courses arranged for nurses. We think it is possible for other psychiatric training schemes to organise similar courses with the help of trained nursing colleagues. We gather that other training schemes have also organised such courses and we would strongly suggest still more did so.

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Training in neurology

DEAR SIRS

I was most interested to read Dr Hughes' article on the value of the physical examination in psychiatry (*Psychiatric Bulletin*, 1991, **15**, 615–616). I am concerned about his findings, in particular with regard to the poor way in which the neurological examination was carried out. I agree with him that it is very important to exclude treatable pathology in the nervous system in psychiatric patients.

I would like to propose two ways of improving the situation.

More emphasis should be placed on training in neurology during postgraduate training for psychiatrists. Perhaps rotational training schemes should include a six month period in a department of neurology. This would also improve the management of psychiatric patients with chronic neurological problems.

The quality of neurological examination would improve if psychiatric units used detailed standardised neurological examination forms, with adequate spaces to note the findings. This is done in many neurology units. The forms I have seen used in psychiatric hospitals to record the physical examination leave very little space to record nervous system findings. (The ones I have seen allowed a quarter of one side of A4 paper for this.)

I feel that the detection of treatable neurological disease is a vital part of the psychiatric evaluation. Perhaps more units should audit this area of practice and changes could then be implemented.

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Use of clozapine

DEAR SIRS

I refer to the letter by Ball & Lipsedge (*Psychiatric Bulletin*, 1991, **15**, 645–646), concerning the use of

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