Correspondence

Holding powers in A&E departments

Sir: Nicholls (*Psychiatric Bulletin*, October 1997, **21**, 615–617) describes the difficulties in managing psychiatric emergencies in accident and emergency (A&E) departments, describing the case report of a detainable patient awaiting transfer to a psychiatric hospital who left A&E because nursing staff were unwilling to "observe the patient and dissuade him from leaving if necessary". Nicholls believes the problem revolves around contradictory and deficient legal provisions for the care of the mentally ill presenting to A&E departments.

We experience similar problems in Edinburgh where A&E nursing staff are resistant to sitting with psychiatric patients or participating in their care. A recent initiative to provide trained psychiatric nurses on-call with the duty psychiatrist has had its funding stopped and there are safety concerns about unsupported psychiatrists attending A&E. Rather than displacing our concerns onto mental health legislation we need to challenge this further discrimination against mental illness. Psychiatric emergencies should be managed like any other medical emergency with skilled nursing available throughout a patient's stay in A&E and in transfer to a psychiatric bed. It would be unthinkable for A&E to refuse to provide nursing care for a medical patient with a heart attack while awaiting transfer to a medical ward. Similarly, the medical registrar involved would never be expected to remain with the patient until transfer.

Psychiatric patients are unwelcome in A&E departments. They are seen in a negative light – unpredictable, uncooperative, dangerous and manipulative – with their care detracting from that of the physically unwell due to the demands they can make on staff time. Difficulties exist in providing an effective emergency service to psychiatric patients which ensures their safety as well as the safety of staff and other users of A&E. Psychiatric emergencies have as much right to good care as physical health emergencies.

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Methods of registrar post allocations

Sir: Ramchandani *et al* identified four main methods of post allocation (*Psychiatric Bulletin*, November 1997, **21**, 711–713). A fifth method, stand-alone, six-month placements, should also be considered: this is widely used in other specialities. The lack of continuity between posts could be problematic for psychotherapy training or research. However, benefits include choice of particular sub-specialities or departments and experience in areas of differing socio-economic backgrounds and in different organisational structures.

While some disadvantages of stand-alone posts may be a particular problem for psychiatric training, their advantages seem particularly important in a speciality where adaptability and a variety of clinical skills, not just pure knowledge, are necessary. A combination of shorter rotations plus six-month posts may provide diversity beneficial to trainees and trainers.

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Video monitoring of dangerous behaviour

Sir: Mental health professionals are not able to predict violence or suicides among psychiatric in-patients. Both cause considerable distress to patients, relatives and professionals, attract unwarranted publicity and sometimes lead to litigation. There is a real need to consider new approaches in monitoring psychiatric in-patients to reduce such behaviours. One such approach is the use of video cameras (Shah & Ganesvaran, 1993).

In usual clinical practice, patients who pose a potential risk to abscond, to harm themselves or others and those in seclusion rooms are observed by nurses. Video cameras could be a useful adjunct in these situations. A single nurse could observe more than one patient at a time, leading to early detection of these behaviours, particularly in the ward's architectural blind spots. The risks are that the nursing staff may become too complacent and diminish direct contact with the patient. This would prevent development of a therapeutic alliance and may compromise the quality of care.

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