Correspondence

Psychiatrists as custodians of public safety?

Sir: I wish to express my fullest support for Paul Bowden's editorial (*Psychiatric Bulletin*, February 1995, **19**, 65–66). Both his editorial, and Dr Boyd's paper (*Psychiatric Bulletin*, February, 1995, **19**, 104–105), raise a crucial ethical issue – the extent to which psychiatrists are required to protect the public from harm. It is now clear that this issue is now the legitimate concern of all psychiatrists, and not confined to forensic psychiatry.

Psychiatrists are currently being asked to do something that other law enforcement agencies are not. The Home Office is not sued when violent criminals, justly released at the end of their sentences, re-offend. Policemen are required to investigate violent crime, not prevent it, and are indemnified against prosecution on such grounds. Psychiatrists have no such protection, and are increasingly required not only to foresee the risk of any violent crime, but also prevent it. If psychiatrists are required to act as accessory policemen, then they should have access to the same training as policemen, and the same indemnity.

To date, the right-wing press, tacitly supported by the Department of Health, has been deciding what psychiatrists' professional duties should be. They, not we, have decided that psychiatrists should be responsible for the conduct of other adults; something which is legally and philosophically unjustifiable.

As a professional group, we must wrest back the initiative, and claim some right to determine the limits of our own professional competence. Clearly, other social groups will have a part in this process. But the view of a "body of reasonable psychiatric opinion" must have greater weight than that of tabloid newspapers, if only because we can marshal years of clinical experience and research to back our claims. It is time to be bullish; if we do not get proper air-time, column space, and Parliamentary time to inform and educate the public, then we will be forced into a type of psychiatry that we thought we had left behind 40 years ago. Very few of us trained to become zookeepers or custodians of public safety, but these are the roles which are being insidiously offered as proper for a psychiatrist.

GWEN ADSHEAD, *Institute of Psychiatry, Denmark Hill, London SE5 8AF*

Sir: I suspect that Dr Bowden, in his editorial on the 'Confidential Inquiry into Homicides and Suicides by Mentally Ill People. A Preliminary Report on Homicide' (*Psychiatric Bulletin* February 1995, **19**, 65–66) speaks more effectively for the majority of practising clinicians than Professor Sims or Dr MacKeith (*Psychiatric Bulletin*, March 1995, **19**, 173–180).

At last we know that the College's tacit acceptance of the care programme approach now enshrined in every tenet of operational policy was due to its enshrinement of "traditional values of good psychiatric practice". Where is the evidence that this theology was ever tested, quite apart from being demonstrated to have value for acute general psychiatry? Did the College ever question the absurdity of the Department's guidelines that the CPA should apply to every patient referred to the specialist mental health services and the implications of such a blunderbuss recommendation for the huge number of individuals who fleetingly encounter our junior psychiatrists in accident and emergency departments or drop-in services? Do we feel any responsibility for the disapprobation that will undoubtedly fall upon our most junior staff or the ubiquitous key-worker who will have been expected to anticipate the vagaries of the human condition and then blamed for not adhering completely to the details of the CPA and supervision register?

Some of us had hoped that the initial muscular response of the College to the Department's promulgation of the supervision register implied a recognition that documentation and bureaucracy were inappropriate substitutes for adequate resources. Unhappily it preferred the private

arguments with Department of Health Officials that Dr MacKeith was party to, but left the rest of us wondering whether we were not followers of the Grand Old Duke who was not so much passive as hasty in retreat.

ROBIN PINTO, *South Beds Community Health Care Trust, Calnwood Road, Luton LU4 0FB*

Sir: Dr Robin Pinto expresses anger at the care programme approach and the way it was introduced. I share completely with him dissatisfaction over the manner of its introduction. It was not properly discussed with the profession before being foisted on us; the documentation was abstruse to the extent of being misleading; we were never told how we would obtain resources to make it work; it was not specified who appoints the key-worker nor who that key-worker should be; and it was not clear who among the total of psychiatric discharges would be subject to the CPA. For all these reasons the manner of introduction of the CPA was little short of disastrous.

On the other hand, the principles which underline the care programme approach are simply those that psychiatrists have tried to practise for many years. When a patient is discharged from in-patient care it is reasonable that one individual should be identified to give adequate level of follow-up; if after-care involves social services and the health service, then reasonable liaison between the two authorities needs to be arranged; before discharge takes place there should be a plan agreed and accepted by all those involved to maintain the patient at the optimum level outside hospital.

These principles of care are reasonable. However, to be implemented, psychiatric services must have adequate resources; there must be enough consultant psychiatrists to look after the patients in the community who still require treatment and follow-up; the consultant needs to be able to identify the appropriate key-worker for each patient discharged into the community; it must be possible to agree with other authorities who takes responsibility for what parts of care, and who pays for it.

It is my opinion that rather than attacking the underlying principles of the care programme approach, Dr Pinto would more profitably spend his time working with us to achieve what is needed to implement it, both locally and nationally. We want to provide an improved level of psychiatric care to our patients but it cannot be done without additional resources and adequate control by consultants of the facilities we already have.

A. C. P. SIMS, *Chairman, Steering Committee, Confidential Inquiry into Homicides & Suicides by Mentally Ill People, PO Box 1515, London SW1X 8PL*

Fund-holding practices and follow-up clinics

Sir: Armond (*Psychiatric Bulletin*, February 1995, **19**, 177) highlighted potential problems in respect of fund-holding practices taking over the supervision of lithium prophylaxis of patients.

I was shocked last year to receive a letter from the fund-holding practice manager terminating further appointments and saying that follow-up would occur in the general practitioner's surgery. This patient, who I had been seeing for 12 months, suffered from a mild depressive disorder, largely related to his chaotic personal life. Management had involved supportive psychotherapy with problem-solving techniques and cognitive strategies to reframe pessimistic thinking. Matters had improved to the point where the patient anticipated returning to work. I wrote outlining his progress and planned one more appointment to confirm the improvement and then discharge.

I wrote to the GP expressing my disappointment and asking for clarification, including knowledge of whether the patient had been informed. I received another letter from the practice manager (not the GP) telling me that the practice had been arranging their own follow-up clinics for some time and that "as a matter of courtesy we inform the provider in good time so that they could reallocate the appointment to someone else". The writer trusted that I found the explanation satisfactory. I found the response of the local purchasing authorities more bland but equally unsatisfactory in that there seemed little more to be done about the matter *vis-à-vis* local management although the response was more positive from the Chair of the Regional Mental Health Services Committee.

The final icing on the cake was when, on the day and time of the appointment, the patient arrived with no knowledge of what had been happening but considerable surprise and anger when informed of it.