columns

Most trainees did not report any experience with systemic/family therapies. However, a majority of trainees had attended interview skills training courses and case discussion/Balint groups.

Information from college tutors suggested that all responding hospitals offered interview skills training and an active case discussion/Balint group. Psychotherapeutic skills were included in educational contracts of trainees in a smaller majority of responding hospitals. Individual-therapy training and supervision (in supportive-dynamic and/or cognitive modalities) was available (locally or through regional psychotherapy departments) in all responding hospitals, but systemic therapy experience was limited to only few hospitals in the region.

The findings suggest that resources are available to introduce trainees to psychotherapy at a basic level, but may be less adequate to meet individual and systemic therapy training needs of more senior trainees. There is a need to develop a regular and accessible system of supervision of trainees in individual (especially cognitive) and systemic therapies in the region.

BATEMAN, A. & HOLMES, J. (2001) Psychotherapy training for psychiatrists: hope, resistance and reality. *Psychiatric Bulletin*, **25**, 124–125.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) Requirements for psychotherapy training as part of basic specialist psychiatric training (Bateman, A.W. (convenor), Anderson, H., Bhugra, D., Freeman, C., Hughes, P.). London: Royal College of Psychiatrists.

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Re: Unpacking Personality Disorder

I read with interest Peter Snowden and Eddie Kane's Editorial on personality disorder (*Psychiatric Bulletin*, November 2003, **27**, 401–403). It appears to me that personality disorder will be broken down into multiple subtypes in the future. The two particular subtypes I have become aware of are those with personality disorder who also meet the criteria for adult attention-deficit hyperactivity disorder (ADHD) and have had childhood ADHD. This type will need the underlying ADHD to be treated. The second type is an autistic psychopathy which was described by Hans Asperger. It appears to me that a small number of patients with personality disorder meet the criteria for autistic psychopathy or Asperger syndrome, and these will require treatments focusing more on theory of mind skills and empathy deficits (Fitzgerald, 2001).

FITZGERALD, M. (2001) Autistic psychopathy. *Journal of the American Academy of Child and Adolescent Psychiatry*, **40**, 870.

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the college

The Royal College of Psychiatrists and the Law

Colleagues will be aware of the College's submissions in relation to planned legislative changes such as the Draft Mental Incapacity Bill and the Draft Mental Health Bill.

It is very much less common for the College to become directly involved in court cases. This has happened, to a greater or lesser extent, in three recent and important cases.

Colonel Munjaz and Mersey Care National Health Service Trust and S. and Airedale NHS Trust and (1) The Secretary of State for Health and (2) The National Association for Mental Health (MIND)

This was a Court of Appeal hearing in relation to the two cases mentioned above. Both cases related to the legality of seclusion and the status of the Mental Health Act 1983 Code of Practice. In the former case (Colonel Munjaz), the patient had taken action against Ashworth Hospital because the seclusion policy and practice at Ashworth was not in line with the Code of Practice. In the latter case (S.), the patient took action against Airedale Hospital because of the specific circumstances in which he was kept in seclusion, again being outside the parameters set out in the Code of Practice. In both circumstances, the patients had lost their cases in the High Court and both had appealed. The Court of Appeal heard both appeals together.

The National Association for Mental Health (MIND) was extremely concerned about the judgements because both Judges had appeared to diminish the importance of the Code of Practice. MIND approached the College, through me, to ask if we would be prepared to make a statement that could be included in their submission. I made a formal witness statement on behalf of the College, giving examples as to why we thought it essential that the Code should be considered the usual standard of practice other than in defined circumstances and for good clinical reasons.

The final judgement concluded that the policy in Ashworth was unlawful and Airedale were not justified in keeping Mr S. in seclusion for the length of time that they had done so. The Judgement made mention of the College's submission and said the following:

> 'hence we conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient. They may identify good reasons for particular departures in relation to groups of patients who share particular well-defined characteristics, so that if the patient falls within that category there will be good reason for departing from the Code in his case. But they cannot depart from it as a matter of policy and in relation to an arbitrary dividing line which is not properly related to the Code's definition of seclusion and its requirements'.

The Queen (on the application of I.H.) and (1) Secretary of State for the Home Department and (2) Secretary of State for Health and (3) East Midland and North East Region Mental Health Review Tribunal and (4) The Royal College of Psychiatrists and (5) Nottinghamshire Health Care NHS Trust

This was heard in the House of Lords.

I.H. was a patient in Rampton Hospital detained under Section 37/41 Mental Health Act 1983 (MHA). A Mental Health

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