

New Zealand – A trainee's paradise?

Sir: I read with interest Wilkie's briefing on working as a psychiatrist in Australia (*Psychiatric Bulletin*, 1996, **20**, 558–560). As an alternative in the Antipodes for British graduates I would suggest considering New Zealand. Temporary registration for three years is open to British and Irish graduates following approval of their documentation. Registered doctors can practise without condition in hospitals or general practice throughout the country.

The rules on immigration depend on the class of visa applied for. A work visa for 12 months requires the offer of a post. An application for a residency visa is more complicated but can be worth the effort involved should you score well on the points system. Maximum points are awarded to professional people between 25 and 29 years of age, speaking English and who have been in full time employment in Europe. A penalty is not incurred for possessing a medical degree as happens in the Australian points system. In New Zealand there is a shortage of trainees in psychiatry. Finding a training post with good teaching in one of the major cities is not difficult.

I spent a 12 month period working in New Zealand where the culture has many similarities to the UK and wonderfully exciting differences. Salaries for doctors give a good standard of living where food and wine especially are cheap. Whether you live in the North or the South Island you are never far from exciting outdoor activities such as skiing in September, sailing at any time or "tramping" in the bush. As an opportunity for training in psychiatry combined with a chance to experience life in a society beyond Europe, there is nowhere more accepting of doctors, nor more agreeable than New Zealand.

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24 hour psychiatric services

Sir: Rampes & Sireling (*Psychiatric Bulletin*, October 1996, **20**, 622) fear that if informal carers have 24 hour direct access to the psychiatric team this will lead to overloading secondary services with unnecessary contacts and deskillling GPs. In over 20 years of direct experience with carers, I have found views falling into two broad camps over this question. There are those who count themselves 'lucky' who have a 'wonderful' GP, who listens to them, trusts their view of the situation, is willing to make home visits when the patient will not attend the surgery and liaises appropriately with psychiatric and other services. These carers rarely see the need for a 24 hour direct access service. They already have an appropriate and functioning 24 hour service.

Other carers describe their GP variously as 'not interested', 'doesn't care', 'doesn't know anything about schizophrenia'. These are the GPs who do not listen to carer's concerns, who do not understand the pressures and burdens of living with someone with severe mental illness and who, most tellingly, will only see the patient if he/she attends the surgery. Pleas of 'but he doesn't think there's anything wrong' are dismissed. The patient has to ask to see the doctor, and, since they can walk, must attend surgery. These are the carers who want 24 hour direct access because they have no other way into services. Rather than such a service deskillling GPs it is likely to be seen as necessary because the GP has no skills.

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Case report

Sir: Henderson & Reveley (*Psychiatric Bulletin*, 1996, **20**, 513–515) highlight the vulnerability of some women on mixed sex wards and the lack of single sex wards for women wanting this option. The following case illustrates the vulnerability of both sexes on mixed sex wards when single sex facilities are not available.

Case Report. A, a 50-year-old man with a 30 year history of admissions for schizophrenia was admitted to a mixed sex ward. His out-of-hours admission was precipitated by a social crisis and he was free of psychotic symptoms. During the course of his admission an allegation of sexual assault was made against him by B, a 33-year-old female suffering from a first-episode psychosis. This allegation was made a week after the event, was relatively minor, inconsistently described and not witnessed. He denied the allegation and he was not charged after a police interview. He has no previous history of inappropriate sexual behaviour. Subsequently, C made an allegation against A and following police interview, the allegation was deemed to be malicious. Following this second allegation he relapsed and was detained under Section 3 of the 1983 Mental Health Act. He recovered on an increased neuroleptic dose and was discharged. He still remains bitter about his experience. B also recovered and had little recollection of the alleged assault. However, after-care arrangements for both patients were complicated by their residence in the same psychiatric sector with neither of them willing to transfer care to a different sector team. Therefore, arrangements were made to ensure that they did not attend for the same out-patient or day-care session.

While B (and her husband) are not concerned about future readmission to a mixed ward, would a single sex ward be a more appropriate environment irrespective of her expressed wishes? In practice an extra contractual referral would have to be made to achieve this care.

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Unexpected therapeutic benefit of Community Care Order application

Sir: I wish to report an unexpected therapeutic benefit of an application for a Community Care Order (CCO). It is not known if the benefit was attributable to the specific features of this new legislation or simply therapeutic attention. The application was made as follows:

Day 1 - Mental Health Officer (MHO) telephoned the patient at home to introduce himself and arrange a home visit. Day 2 - MHO visited and introduced himself as the After-Care Officer (ACO). Responsible Medical Officer (RMO) telephoned later to arrange a visit. Day 3 - RMO visited and introduced himself as the Special Medical Officer (SMO). Both completed a Medical Recommendation. The General Practitioner (GP) telephoned after lunch to introduce himself. GP visited and completed Medical Recommendation.

RMO (not SMO) tried to telephone that evening to obtain further information about the patient's nearest relative whom she last saw in 1975. Telephone engaged; MHO and ACO had telephoned again. Days 4 and 5 - MHO and ACO visited and the latter completed After-Care Report. Day 6 - ACO did not visit the patient, but the RMO and SMO instead. Day 7 (Sunday) - People with acronyms had a day off. Day 8 - Patient shopped in the morning and went to the laundrette in the afternoon, saying that she would not be at home to visitors. Day 9 - As required the RMO delivered the CCO application to the patient before it was lodged with the Sheriff Clerk. RMO told subsequently that he was not competent to tell the patient about the date of the Hearing. A Sheriff Officer was to visit the next morning to notify the patient.

Day 10 - Sheriff Officer did not visit or notify the patient. As required the RMO visited in the afternoon "to encourage" the patient to attend a hearing about which she knew nothing.

Whereas the patient used to be sullen and socially isolated, she was cheerful and no longer socially isolated by the time the application was lodged; she even bought an extra packet of biscuits for her visitors.

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