# 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.

JOHN R MITCHELL, *Senior Registrar, Affleck Centre, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF*

## 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.

JANET BUTLER, *Registrar, Department of Psychological Medicine, King's College Hospital, London SE5 9RS*

## 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.

Managers may consider further reduction in already precarious nursing levels.

Although video monitoring is non-invasive it raises a number of ethical issues (Leong & Silva, 1989). Is there a need for acquiring formal consent from the patient to allow observation through the video camera? Need the multi-disciplinary staff give their formal consent as well? The other ethical issue is the invasion of the patient's privacy. There need be no formal video recording, this instrument should purely be used for 'here and now' observations.

Video monitoring of dangerous behaviours (Brizer *et al*, 1988) is a novel idea and its advantages and disadvantages require formal prospective evaluation, including analysis of cost-effectiveness. Information needs to be collected from patients, relatives, members of the multi-disciplinary team, patient advocacy groups and the Mental Health Act Commission regarding their views on this topic.

BRIZER, D. A., CROWNER, M. L., CONVIT, A., *et al* (1988) Videotape recordings of inpatient assaults: a pilot study. *American Journal of Psychiatry*, **145**, 751–752.

LEONG, G. B. & SILVA, J. A. (1989) Videotape recordings of assaultive inpatients. *American Journal of Psychiatry*, **146**, 287.

SHAH A. K. & GANESVARAN, T. (1993) Can videos be used to monitor psychiatric inpatients? *Australasian Psychiatry*, **1**, 158–159.

DEEPA DIGHE-DEO, *Specialist Registrar, Department of Old Age Psychiatry, West Middlesex University Hospital, Isleworth and* AJIT SHAH, *Senior Lecturer in Psychiatry of Old Age, Imperial College of Science, Technology and Medicine, London*

## The dispensable psychiatrist

Sir: How slowly psychiatrists change. Dr John Kellett (*Psychiatric Bulletin*, September 1997, **21**, 581–582) describes something of the uncertainty that evidently still prevails regarding the new style of psychiatry, quite aside from the pressing problems currently facing the profession.

I have argued (Bennet, 1988) that with the various health professionals becoming increasingly skilled in therapeutic techniques, the psychiatrists should (a) take advantage of their broad basic training which enables them, if they wish, to comprehend everyone else's work in the mental health team, and (b) develop their specific skills and knowledge, which are medical. Members of a multi-disciplinary team share skills, which they use much, or most, of the time. Each, in addition, has specific skills deriving from their basic training: the psychiatrist's is medicine.

I am now more of a spectator of the scene than a participant and I find psychiatrists are often less fulfilled now than they were ten years ago. I wonder how many have really tried to move with the times. It can be genuinely hard for some to conceptualise mental disorders except in terms of diseases, so they perambulate the well-known paths, while other mental health professionals are moving ahead.

The range of therapeutic measures employed by these professionals is increasing, and they cost less to employ than doctors. They are also usually much more open about themselves and have taken the trouble to learn about the various influences on them which have brought them to be the people that they are – influences which they take for granted will underpin and colour the way that they work, and possibly in an adverse way if they are not conscious of them.

Such self-scrutiny is taken as a *sine qua non* for most therapists, but the majority of psychiatrists, probably because of the biological bias of British psychiatry, do not feel that it is necessary to look at themselves. Thus many psychiatrists appear to their non-medical colleagues as hopelessly naive as individuals and lacking the psychological strength to carry the burden of emotionally needy people, without resorting to medication and their traditional sanctions.

As the nineties are coming to their end, the request with which I ended my *British Medical Journal* paper still seems to apply:"Keep up with your general medicine and be more open about yourselves". Can someone tell me if anything really has changed?

BENNET, G. (1988) What should psychiatrists be doing in the 1990s? *British Medical Journal*, **296**, 274–275.

GLIN BENNET, *Formerly Consultant Senior Lecturer, Department of Mental Health, University of Bristol, and Consultant Psychiatrist, United Bristol Hospitals NHS Trust, Bristol*

## Tardive dyskinesia

Sir: We wish to comment on the descriptive review article on the treatment of tardive dyskinesia (TD) by Duncan *et al* (*Psychiatric Bulletin*, July 1997, **21**, 422–425), and bring to the readers' attention the systematic reviews already published in the Cochrane Library (htpp://archie.cochrane.co.uk/info/abstracts/abidx.htm#G06@). One hundred and fourteen different types of interventions were used in 360 clinical trials over the past 40 years (Soares *et al*, 1996). Seventy clinical trials were included in at least one of the systematic reviews. The others were excluded because they were either not