



# the columns

## correspondence

### Merit in past practices

Sir: I read with great interest the elegant contribution of Henry Rollin on 'Psychiatry at 2000' (*Psychiatric Bulletin*, January 2000, **24**, 11–15).

He gives the impression that the decimation of the old mental hospitals was the direct result of Enoch Powell's policy of promoting community care, whereas the process had started in the 1950s by Joshua Carse's 'Worthing Experiment', and had been enthusiastically espoused by many clinicians. The Victorian asylums had been built to house patients with serious disturbances, difficult to envisage in this neuroleptic age, and the appearance of effective antipsychotic medication made the sort of therapeutic milieu they offered both inappropriate and unnecessary. Enoch's vision has failed, not from lack of judgement, but from underfunding.

Dr Rollin writes of the enthusiasm for the physical treatments of the 1950s, which he thinks were illusory and regards his use of them 'with more shame than pride'. In taking this view, I think he does himself less than justice. I came into psychiatry in 1954, and although chlorpromazine was reported on, nobody believed that there could be a drug that controlled schizophrenia; it was much as if today it was claimed that there was a medicine that could cure mental impairment. The wards were full of violent, suicidal and deeply disturbed people. The majority were overwhelmed by hallucinatory experiences and their behaviour unpredictable, in spite of the gallons of paraldehyde that were dispensed. The relief afforded to 'involutional melancholics' by electroconvulsive therapy (ECT) was dramatic, and the treatment worked like magic on people suffering from catatonia. Although, the remission produced in schizophrenia by ECT usually lasted only a matter of months. However, it could last as long as a year, and permitted some patients to live outside hospital. But the real point is that uncontrolled schizophrenia causes its victim immense suffering, tormented as he or she is by false perceptions, and anything which could relieve the condition was not, in my view, illusory.

In the past all of us made mistakes, but it might be worth considering if some of

the old discarded practices did not have some merit.

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### Obtaining a part-time consultant post

Sir: Caswell & Lowe (*Psychiatric Bulletin*, February 2000, **24**, 64–65) discussed whether part-time training will lead to a part-time consultant post. They concluded that there is little current availability of such posts in their surveyed area which resulted in fully trained psychiatrists considering working in non-career grade posts. With such a recruitment problem in psychiatry this seems a great waste.

Part-time trainees wishing to work part-time as consultants need to take the matter into their own hands and publicise themselves to the trusts in which they would like to work. This strategy has recently worked successfully for me in gaining a part-time consultant post.

The high number of consultant vacancies in psychiatry means that those managing the services need to think imaginatively about using people trained to consultant level in a flexible way. But they need to know that they exist, so that jobs can be changed to suit the needs of the prospective candidate. Job-sharing is often proposed, but does not seem to be a good solution for unfilled consultant posts. There are many problems in job-sharing partnerships – both for the job-share partners and their employing trusts.

Part-time trainees in psychiatry are consistently shown in surveys to be highly motivated and qualified people who need urgently to be included in workforce planning.

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### 'Haltlose' type personality disorder (ICD-10 F60.8)

Sir: There is indeed no English equivalent word to describe 'haltlose' personalities (Cullivan, 1998). The word indicates a drifting, aimless and irresponsible lifestyle: a translation might be 'lacking a hold' (on life or onto the self).

This personality has, in English-speaking countries, been described as "the unstable psychopath" (Slater & Roth, 1979). Schneider (1992) used the descriptor "*Willenlose Psychopathen*", indicating the absence of intent or rather a 'lack of will'. People with chronic alcohol dependency have been said, not uncommonly, to have haltlose personality disorder.

Those with haltlose personality disorder have features of frontal lobe syndrome, sociopathic and histrionic personality traits.

- (a) He or she lacks concentration and persistence and lives in the present only. His or her immediate affects, moods and interests rule completely; he or she has no interest in the future, and no hold in the past: in this sense he or she is quite at mercy of the environment. He or she is certainly easily persuaded, and is often led astray by the surrounding persons, sometimes criminals.
- (b) He or she mixes well with sociopaths as he or she also has an inability to learn from experience, and no sincere sense of remorse for his or her actions.
- (c) In common with the histrionic personality he or she has a number of endearing qualities: charming with an apparent emotional warmth, but also an enhanced suggestibility and a superficiality of affect. He or she is usually overoptimistic and pleasant to be with. This makes him or her quite a likeable character, the 'lovable rogue' which we sometimes see in our substance misuse clinic.

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## Enough of the sticks, what about some carrots?

Sir: Palmer & Lelliott describe some important aspects of guideline implementation (*Psychiatric Bulletin*, March 2000, **24**, 90–93). Encouraging doctors to change their practice is a difficult task. Examples of published audits confirm this (Duffet & Lelliott, 1998).

As well as considering vigorous strategies for implementing change, we wonder if more emphasis should be placed on provision of reward systems for guideline compliance. Doctors prefer to rely on clinical experience for their decision-making (Dickson-Mulinga, 1998). In contrast, guidelines can be viewed as sinister threats to this professional autonomy. Clinical experience follows an operant learning model. 'Good' clinical decisions are rewarded by patient improvement. 'Poor' clinical decisions are so labelled because they result in patient deterioration. The perceived reward for following guidelines must be greater than the integral reward predictable from a good 'clinical experience'-based decision.

General practitioners receive financial incentives for reaching targets for preventative medicine interventions. If a change in practice is perceived as an increased workload, financial compensation can soften the blow. Rewarding high quality practice makes sense. Although this may add to the unit price of change, this system may prove cost effective. Further research evaluation may be indicated, of course. Producing and disseminating guidelines that nobody reads or follows, is surely an ultimate waste of time and money.

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## Substance use and misuse in psychiatric wards

Sir: I was interested to read the overview provided by Williams & Cohen (*Psychiatric Bulletin*, February 2000, **24**, 43–46).

In our hospital, we have found that establishing a close liaison with our local police service to advise us and support us has been helpful in dealing with this issue. I am aware that some units have used 'sniffer dogs' on wards to give the message that illicit drugs are illegal, and having an occasional police presence does at least deter dealers from visiting the wards.

The local police have also been helpful in providing drug awareness sessions for our staff and offering advice and support in dealing with difficult problems, taking a non-judgmental approach.

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## Royal College Music Society

Sir: Although I am not a golfer I was delighted to read Chris Thompson's account of the inaugural meeting of the Royal College Golf Society and would wish to give my congratulations to Robert Jackson. I note that this Society is planning a further meeting at the end of the Annual General Meeting in Edinburgh.

My prowess in golf is more limited than my interest in music. Most of our now defunct mental hospitals used to have sizeable orchestras, some of them conducted by their medical directors. Edward Elgar used to conduct the Powyck Mental Hospital Choir and composed music specifically for its musicians. There is now a broader consensus that psychiatry is a science, as well as an art, certainly that psychiatrists and other mental health professionals have both left and right hemispheres which need exercising. Judging by the curriculum vitae of many of my colleagues and of trainees applying for postgraduate posts, there is an abundance of artistic talent among our membership. I will try to convene an inaugural meeting of anyone interested in pursuing these specific matters further. If there is sufficient interest we could even

arrange a very fringe event in Edinburgh during, or shortly after, the formal proceedings.

**John L. Cox** President, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

## 2nd PAN conference in Kathmandu

Sir: The Second International Conference of the Psychiatrists' Association of Nepal (PAN) was held on 13–14 November 1999 in Kathmandu. The lecture entitled 'Mental Health at the Doorsteps' marked the PAN journal launch. The conference centre was a large hotel where hospitality was generous, and the gardens provided a relaxed setting for networking.

Delegates from Asia, Australia and Britain attended. The topics included: mental health in women; psychiatric training of health workers and its evaluation; liaison with traditional healers; child psychiatry in the context of a changing culture; substance misuse, and mental health needs of a growing elderly population.

Many speakers referred to two major constraints on mental health care delivery: the very small number of psychiatrists (20 for a population of 21 million) and the provision in remote areas. The introduction of telepsychiatry to overcome these constraints was canvassed and debated. The expenditure required for the network could be offset by the consultation costs for patients and their relatives who customarily accompany a patient (cost of journey, food, accommodation, loss of income during travel and the hospital attendance – it is common to travel for several days for an appointment). Reduced patient–doctor contact was a concern regarding telepsychiatry, however, it should not be seen as a substitute for psychiatric consultation and teaching, but as a pragmatic alternative to the absence of service provision in remote areas.

The Kathmandu Valley provided an unforgettable setting. This will be an annual event and information can be obtained from the Mental Health Resource Centre, e-mail: sregmi@health-net.org.np.

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**'Haltlose' type personality disorder (ICD-10 F60.8)**

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