Antidepressants and the risks of untreated illnesses

Sir: As always, David Healy provides a stimulating point of view in his survey of the fashions of 20th century psychiatry (Psychiatric Bulletin, January 2000, 24, 1–3). But when it comes to antidepressants, a critical viewpoint seems to have been abandoned for anecdotal smears.

We are told that “the complete transformation of personality . . . was becoming the goal”. Who’s goal? Where is the evidence that any scientist or any company has had this as an objective? David Healy said that it was “most clearly articulated” in Kramer’s (1993) Listening to Prozac. But as a scientist, he surely cannot authenticate that worthless collection of clinical anecdotes, combined as it was with a naive misconception of the role of serotonin. Interestingly, none since Kramer has claimed similar achievements.

More seriously, David Healy reports an American high school massacre, where there were “suggestions that one of the teenagers had an antidepressant in their (sic) blood stream”. Were these suggestions true? If so, which antidepressant was involved and were any other drugs present? Was the other teenager drug-free? If so, what difference did the unidentified antidepressant make? And what about the numerous other incidents of this kind in recent years?

Healy considers none of these critical questions, but quotes without comment a statement by the American Psychiatric Association President which emphasised the dangers of untreated mental illness. So far as one can make out, we are supposed to feel contempt for this statement, all because of ‘suggestions’ as to what might have happened at a particular school. Does he believe there are no risks from untreated mental illness?

If David Healy wants to argue a case, he should do so on the basis of facts, rather than suggestive smears and half-truths.


Hugh L. Freeman Professor of Psychiatry, 21 Montagu Square, London W1H 1RE

Sir: As an editor, Hugh Freeman will appreciate that covering a century’s sweep risks giving hostages to fortune on specific details. I focused on how therapy establishments have a habit of blaming the disease and not the treatment. Professor Freeman does not disagree that this is what the psychoanalytical establishment did. An article in the Psychiatric Bulletin in 1981 predicted a similar dynamic would develop within biological psychiatry. My contention is that it has. Whether Eli Lilly were the first to formulate ‘a blame the disease not the drug’ defence for therapeutic failure is not established, but I have documented in detail that this did happen (Healy, 2000).

In the Colorado shootings, the lead teenager was taking fluoxetine. The emotional indifference that selective serotonin reuptake inhibitors (SSRIs) can cause may have contributed to this tragedy. I do not claim that it did so, but the response of the American Psychiatric Association to deny the possibility is based on neither research nor decency.

As regards perceptions that SSRi use is being aimed at personality transformation rather than simply the treatment of disease, there is a recent series of articles on this issue (Elliott et al, 2000). There is also growing concern that many preschool children in America and Britain are receiving SSRIs (Zito et al, 2000). What disease is being treated here?

References


Community treatment orders

Sir: Trevor Turner et al compare the arguments for community treatment orders (CTOs) with those used to justify car seat-belts (Psychiatric Bulletin, April 2000, 24, 153). The comparison may be apt, but not necessarily as they intend.

John Adams, Professor of Geography and expert on transport, has reviewed social, cultural and practical aspects of ‘risk’ from a wider perspective than is generally found within psychiatry (Adams, 1995). His view of the results of seat belt legislation is unequivocal:

“the law produced no net saving of lives, but redistributed the burden of risk from those who were already the best protected inside vehicles to those who were the most vulnerable outside vehicles.”

This occurs because people wearing seat-belts drive (marginally) more dangerously. Adams suggests:

“if all motor vehicles were to be fitted with long sharp spikes emerging from the centre of their steering wheels (or, if you prefer, high explosives to detonate on impact), the disparities in vulnerability and lethality between cyclists and lorry drivers would be greatly reduced. There would probably be a redistribution of casualties, but also a reduction in total number of casualties.”

Seat-belts reduce driver deaths – but not deaths overall. Although common sense suggests them to be unarguably a good thing, life is more complicated. Are homicide and suicide inquiries equivalent to Adams’ spikes or high explosives? In some ways. Does it help to fit spikes to steering wheels? Some drivers probably stop driving altogether or at least take early retirement. In terms of risk, will CTOs prove to be like seat-belts? If so, Turner’s or Adams’?

Reference


*Philip Lucas Consultant Forensic Psychiatrist, John Howard Centre, 2 Croydener Terrace, London E9 6AF, Hilary Scullock Consultant Psychiatrist, Mental Health Unit, Chase Farm Hospital, Enfield EN2 8L.
Illicit drug misuse in mental health units

Sir: We were interested to read Williams & Cohen’s (Psychiatric Bulletin, February 2000, 24, 43–46) reminder of the difficulties for front-line staff in managing the problem of illicit drug use in mental health units. They suggest that “clear procedures to control substance misuse are necessary . . . for the legal protection of staff” in addition to policies covering patient and visitor searches, consultation with local police and “how far can and should confidentiality be protected.”

Their comments are pertinent in the light of the recent sentencing of two Cambridge-shire hostel workers to four and five years’ imprisonment under the ‘Premises’ section of the Misuse of Drugs Act, which makes it a criminal offence for third parties to knowingly permit heroin or cannabis use in their property, in this case a homelessness day centre (The Guardian, 10 December 1999). Although suspected drug dealers were banned from the centre, staff refusal to give the names of alleged drug users to the police on the basis of confidentiality was seen as “deliberately obstructive” behaviour.

With the reported prevalence of comorbid psychotic and substance misuse disorders being high and with such patients spending longer in hospital (Menezes et al, 1996), legal issues surrounding the presence of alcohol and drugs in mental health units are bound to occur. It would be detrimental to an already (dual) disadvantaged group of patients if staff felt unsure or even afraid of the legal consequences of their management relating to prohibited substances and we too urge trusts to offer clear guidance for the protection of both patients and their staff.

Reference

*John Milton Lecturer in Forensic Mental Health, East Midlands Centre for Forensic Mental Health, Arnold Lodge, Cordelia Close, Leicester LE3 0LE, e-mail: milton@ineone.net, Ira Unell Lecturer in Substance Misuse, Leicestershire NHS Drug and Alcohol Service, Drury House, 50 Leicester Road, Narborough, Leicestershire LE9 5DP

Time for locked drug free psychiatric wards?

Sir: Illicit drug use is endemic in our society, and therefore also in our hospitals. Psychiatric hospitals look after a particularly vulnerable patient group in which drug misuse complicates management and can lead to accidental death. In the article by Williams & Cohen (Psychiatric Bulletin, February 2000, 24, 43–46) they point out gaps between hospital policy and practice, in the context of clinical governance. However, I feel this only begins to address one of the fundamental issues. The issue is tolerance of people’s lifestyles particularly when an in-patient is held, using a Mental Health Act section, against their will. However, something is wrong if this tolerance puts at risk other patients through the availability of drugs on a ward because the ‘culture’ is one of drug use among the peer group.

Discharge is not always an option due to the clinical condition of the patient and the element of ‘proof’ of supply is always a difficult task. At the current time staff struggle on with treating and support and develop an increasingly antagonistic attitude to drug users. An accident is waiting to happen, and the hospital trust could be seen as liable.

The options, as I see it, once all patients are screened on admission for illicit drugs in or on them, is that drug users go to the ‘open drug’ wards. The other patients being put in ‘drug-free’ wards. Alternatively, if the concept of open drug wards is a step too far, then the patients who would have gone to the open drug wards instead go to a locked drug-free psychiatric ward. However, even in a locked unit it is difficult to keep drugs out, but at least it would protect other patients who need and want to be in a drug-free environment.

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Use of the Mental State Examination by psychiatric trainees

Sir: I agree with Kareem & Ashby (Psychiatric Bulletin, March 2000, 24, 109–110) that the Mental State Examination (MSE) is fundamental to psychiatric evaluations. The result of their audit showing inadequate recording of the MSE by psychiatric trainees, although the presentation of the data begs a number of questions, is, therefore, a cause for concern.

“A standardised format” is suggested as the solution lost trainees should “employ their discretion” such that “important MSE headings and parameters are often unexamined and unrecorded.” The implication is that as long as every box on the audit sheet can be ticked then all will be well with the world. Surely the important thing is the content and quality of the MSE and that it meaningfully relates to the patient’s condition at the time. Of course, the form in which this information is set out is relevant, but making an industry out of this is to miss the point. There is, excluding hair-splitting, a well-established convention for recording the MSE and a trainee forgetting to ask about abnormal perceptions (or indeed to examine the nervous system) is down to the trainee and not to the absence of a proforma.

I would also argue that it is self-evidently the responsibility of the consultant, as the educational supervisor of the trainee and the doctor in charge of the patient’s care, to review the quality of information in the case notes, including admission-clerking and MSE, as well as admission and discharge summaries and clinic letters. How else is one to know what the standards, strengths and weaknesses of a trainee in these important areas are and, therefore, to be in a position to help them to address any shortcomings and contribute to an improved level of clinical care? The audit process can be useful, but is not an alternative to the fundamentals of good practice or the rigorous clinical teaching of trainees, nor should it have to be a means to this end.

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Implications of community treatment orders

Sir: I should like to comment on some of the points made by Llewellyn-Jones & Donnelly (Psychiatric Bulletin, March 2000, 24, 16–17) in their letter about community treatment orders (CTOs). First, they minimise the importance of the side-effects of medication. These are not only extrapyramidal in nature, but encompass a large number of other undesirable symptoms, which many patients, quiet reasonably, do not wish to experience. Their observation that tardive dyskinesia can occur in patients who have never taken medication is a non-sequitur — would they similarly dismiss the role of smoking in causing lung cancer on the grounds that some people who do not smoke also develop the disease?

Second, the suggestion that psychiatrists might have a ‘duty’ to enable their patients to comply with treatment in the community is a dangerous one, as it implies that in certain circumstances we are ‘morally obliged’ to go against people’s wishes for their own good. This is a familiar argument which has been used to justify various forms of coercive and/or radical treatment (including psychosurgery — see for instance William Sargant’s (1967) The Unquiet Mind). No doubt psychiatrists, just as much as doctors in other fields of medicine, would like their patients to comply with the treatment
they prescribe and feel that they would be better off as a result. Whether this should be enforced by legislation is another matter.

Compulsory treatment in the community raises important issues, several of them discussed in the original article by Moncrieff & Smyth (Psychiatric Bulletin, November 1999, 22, 544–546). Many mental health workers are justifiably concerned about the implications of CTOs for the relationship between professional and patient as well as for individual patient rights. I do not think that Llewellyn-Jones & Donnelly offer persuasive arguments in their favour.


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Help cards for patients

Sir: We wish to report our experience of developing a help card for patients who commit deliberate self-harm (DSH) attending a general hospital. A previous local study identified difficulties with assessments and planning interventions (Gordon & Blewett, 1995). In Bristol the effectiveness of offering access to specialist telephone help following DSH has been examined with variable outcome between subgroups (Evans et al, 1999) demanding further study and replication. We propose a slightly different intervention as part of a broader strategy. We asked casualty doctors to offer a pocket-sized card with numbers and hours of availability comprising the Samaritans, Relate, a local alcohol and drugs agency, a line for young people, Rape and Incest crisis, and the National Debt line.

As a first step to understanding its impact we wrote to people discharged from an accident and emergency department after committing DSH. Forty-eight patients returned a questionnaire, of whom 20 reported receiving a card. Of these, 15 thought it a good idea, and six of the seven who used a line said that they found it helpful.

If a voluntary sector based card could be shown to be effective, the implications for joint working are obvious: currently there is a paucity of evidence for voluntary sector DSH interventions generally, and a variety of arrangements between statutory and voluntary sectors have grown up in different localities. The objective value of our findings is limited to an impression of user acceptability. In an attempt to examine the effect on repetition of DSH, the card is now subject to a randomised controlled trial, and forms part of our patients’ management delivered by a specialist DSH team. We would value the opportunity to share our experience with others interested in treating this patient group.

References


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Use of Section 62 in clinical practice

Sir: Like Johnson & Curtice (Psychiatric Bulletin, April 2000, 24, 154), we have also audited the use of Section 62 (urgent treatment). We studied all Section 62 forms completed at St Andrew’s Hospital during 1997. A total of 55 forms were audited, 53 authorising medication and two authorising electroconvulsive therapy (ECT). This contrasts with Johnston & Curtice who found Section 62 was used exclusively for ECT. These findings are likely to be due to differences in patient characteristics between the two studies. St Andrew’s has many tertiary NHS referrals including forensic patients, whereas Johnston & Curtice were studying patients of a local psychiatric service.

In our audit, aggression towards self or others and generally disturbed behaviour were the most common reasons for using Section 62. Antipsychotics followed by benzodiazepines were the most frequently administered medicines. In 33 instances patients receiving treatment authorised by Form 39 urgently required additional medication to that certified. Fourteen patients withdrew their consent to treatment at the same time displaying an urgent need for medication. A disproportionate number of Section 62 cases involved adolescent female patients. In virtually all cases treatment authorised by Section 62 appeared genuinely urgent.

We are concerned about the Government Green Paper Reform of the Mental Health Act 1983. It proposes that the threshold for administering emergency medication be increased such that merely preventing violence or self-harm would not be sufficient grounds to authorise urgent treatment. This raises concern about staff and patient safety particularly in forensic settings. Psychiatrists will no longer be able to give urgent ECT to patients who lack capacity or do not consent but must wait for authorisation from a second opinion appointed doctor (SOAD). In our audit SOADs took a mean of 4.8 days to visit and complete Form 39 after Section 62 had been used. If made law this measure is likely to increase the suffering and morbidity of severely depressed patients.

*Camilla Haw Consultant Psychiatrist, Ranji Shankararutnum Associate Specialist, St Andrew’s Hospital, Billing Road, Northampton NN1 5DG

Changes to the MRCPsych examinations

The MRCPsych Examinations were analysed by a professional educationalist, Dr Helen Mulholland, in 1998 and a working party, chaired by the Dean, was set up to examine what changes would be desirable to increase the reliability and validity of the Examination, and to ensure it is in keeping with the principles of ‘adult learning’. In June 1999 the working party agreed that an option appraisal should be made of the alternatives proposed, and that this should be subject to a wide ranging consultation process with all relevant parties. The final recommendations were considered and agreed by the Court of Electors in December 1999.

Part I Examination

At present the Part I MRCPsych Examination consists of a multiple choice
questionnaire (MCQ) examination and a clinical examination. It is taken after at least 12 months’ experience in psychiatry.

MCQ examination
The main issues to be addressed when considering the current format of the MCQ paper were that the ‘stem’ technique often results in non-discriminatory questions, and the format inhibits the testing of competence in diagnosis and aetiology. The peer-referenced marking procedure penalises average candidates in a good cohort. The following modifications have, therefore, been agreed:

(a) With effect from Autumn 2001, the format of all MCQ questions will be modified into Individual Statements, reducing the total number of questions from 250 to 200.
(b) At the end of the Autumn 2000 MCQ Examination, candidates will be asked to complete a pilot examination consisting of 10–15 Extending Matching Items (EMI) which will not contribute to their examination result. An evaluation will then take place of the performance of EMIs against the standard MCQs with a view of phasing in EMIs as appropriate.
(c) The present peer-referencing procedure of marking will be replaced by fairer criterion referencing of MCQ and EMI scores.
(d) Questions where candidates’ responses correlate poorly with their overall performance will be removed and the paper will be re-marked without these questions.

Clinical examination
The Working Party agreed that it was essential to continue to include a long case in the MRCPsych Examination despite its inherent variability. It was concluded that this assessment should be included in the second part of the examination, and that the Part I clinical examination be replaced by an Observed Structured Clinical Examination (OSCE). The OSCE format is suitable for assessing a range of essential core skills that a psychiatrist should possess but is not so effective in the assessment of more complex abilities which must be tested in the Part II Examination.

OSCEs have the advantage of being able to test clinical competence using a number of different scenarios in a relatively short period of time in a well-standardised format. A minimum of 12 stations will be used comprising clinical scenarios including written vignettes, simulated patients and video material. It should be possible to examine 400 candidates in three or four centres using between 50 to 60 examiners.

As the introduction of OSCEs is a major undertaking, a new OSCE Working Party has been set up to oversee this process. Several pilot OSCE examinations will be required and they will not be introduced into the Part I Examination until Spring 2003.

Part II Examination
In view of the increasing number of candidates taking the Examination and the difficulties in finding sufficient clinical centres and examiners, it has been agreed that from Autumn 2001 screening criteria for the written papers in the Part II Examination will be introduced to determine eligibility to progress to the clinical examination.

MCQ papers
In order to address similar concerns to those raised in relation to the Part I – MCQ Paper, it has been agreed that the Basic Sciences and Clinical Topics Papers will be amalgamated to produce one MCQ paper comprising of 200 individual statements, with an emphasis on clinical topics questions.

If EMIs are shown to be successful in Part I, it is proposed that EMIs are also phased into the Part II MCQ Paper in Spring 2003.

As in Part I, the present peer-referencing procedure of marking will be replaced by criterion referencing of MCQ and EMI scores, and all questions with negative bisectional correlations with overall score will be removed and the paper will be re-marked without these questions.

Essay paper
The key aim of the essay paper is to test candidates’ ability to marshal evidence, synthesise and interpret the facts to present a coherent and logical argument. In order to give a greater opportunity to achieve this, it has been agreed that from Autumn 2001 candidates will be asked to write a single essay in 90 minutes with a choice of five topics requiring the integration of knowledge from the subspecialities with themes from general psychiatry.

A new Essay Panel will be established to mark scripts using a standardised marking scheme.

Critical review paper
This part of the Examination is relatively new and it is too soon to make a clear appraisal of any changes which may be required. However, it will be kept under regular review. It has also been agreed that the peer-referenced marking of this paper will be replaced by criterion referencing of scores.

Individual Patient Assessment (IPA)
There are similar problems with the Individual Patient Assessment (IPA) as in the Part I Clinical Examination. In addition, there is currently an excessive emphasis on history-taking and insufficient scope to test clinical reasoning and decision-making. However, it was agreed that it is essential to retain a single case presentation in this part of the examination. In order to address the problems identified, the following changes to the IPA examination have been agreed.

The time of examination of the candidate by the examiners will be increased from 30 to 40 minutes with effect from Spring 2003. In the interview with the examiners:

(a) there will be less time spent on the delivery of the history and greater stress placed on differential diagnosis and management;
(b) there will be an exploration of aetiological factors in more depth and discussion of psychodynamic formulation.

Patient Management Problems (PMP)
At present the vignettes presented to candidates in this part of the Examination are not sufficiently structured, and much of the material presented could be examineable by written paper.

It has been agreed, therefore, that the present PMP Examination will be replaced by a Structured Oral Examination. Standardised vignettes, which will include suggested probes for examiners, will be developed by a new Structured Oral Examination Panel. These will test diagnostic skills, the clinical application of knowledge, basic science and clinical reasoning. Changes to the PMP component will take effect from Spring 2003.

It is hoped that, through careful planning and development of the new examination, candidates and tutors will not be adversely affected, and a more robust instrument will be established for the assessment of candidates’ core knowledge and the ability to apply it in the assessment, management and treatment of patients with psychiatric illnesses.

Provisional dates for implementation of changes to the MRCPsych examination

February 2000
MRCPsych course organisers and College tutors informed of approved proposed changes.
September 2000
Proposed new examination material to be included in MRCPsych courses.

October 2000
Pilot EMI questions at end of Part I Written Paper. (These will not count towards final marks at this stage.)

October 2001
First Individual Statements in Part I and Part II Examination. Introduction of new Essay Examination. Introduction of screening criteria for written papers to determine eligibility for entry into the clinical part of the examination.

June 2002
OSCE: Pilot I.

October 2002
OSCE: Pilot II.

Spring 2003
EMIs to be phased into both parts of the examination. OSCEs to replace the Part I Clinical Examination. Changes to IPA and PMP examinations to be implemented.

Cornelius Katona
Dean
Stephen P. Tyer
Chief Examiner, *Julie Small* Head of Examination Services, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Comments on An Bille Meabhair-Sláinte 1999 (Mental Health Bill 1999)
The Royal College of Psychiatrists offers the following comments on the Mental Health Bill 1999. We trust that overall they will be accepted as both considered and helpful advice. The Royal College of Psychiatrists is pleased that the long overdue upgrade of the mental health legislation is being enacted.

Good mental health legislation is the guardian of civil rights
The omission of both Adult Care Orders, Chapter 8 and protecting mentally disordered patients, Chapter 10, of the White Paper is a serious omission (Department of Health, Government of Ireland, 1995).


The Department of Health states that: “The [prison] medical services should be organised in close relation with the health administration of the community or nation”.

Adult Care Orders
The College is seriously concerned that there are no comments in the Bill in relation to Adult Care Orders. This absence affects the most vulnerable patients with a mental disorder living in the community. It is necessary to provide appropriate care and protection for those who may be vulnerable from abuse, exploitation or neglect. We hope this matter will be addressed.

Some legal mechanisms need to be established for guardianship, such as a Court of Protection and an official solicitor. There is also an absence of legislation in relation to the establishment of community care and the direction of Government policy in this area.

Mentally disordered offenders
We are concerned at the absence of any referral to mentally disordered offenders as contained in Chapter 7 of the White Paper A New Mental Health Act 1995. We need to know what alternative legislation is being considered to address this serious omission.

Definition of mental disorder
Part 1, Section 3
We understand that the definition of ‘mental disorder’ relates primarily to involuntary admission to an ‘approved centre’ as defined in the Mental Health Bill.

The College would advise that the term “significant mental handicap” is both incorrect and not acceptable under current international classification of diseases. We would suggest that “significant mental handicap” be renamed ‘significant mental impairment’.

For the purposes of mental disorder in children, it is the view of the College that conduct disorder should be excluded from involuntary admission similarly to the exclusion of personality disorder in adults.

Involuntary admission
Part 2
Paragraph 11, Section 1: The phrase “The member may either” would be better worded as “the member shall either”.

Involutionary admission
Part 3
We understand that the Inspector will be employed by the Commission and are therefore puzzled that the Inspector’s Annual Report can be independent of the Commission. The roles and division of responsibilities between the Mental Health Commission and the Inspector of Mental Health Services is unclear and needs clarification.

The College is concerned that members may have to take ‘an oath’ before appearing before the Mental Health Commission.

Mental Health Commission
Part 3, Section 31
The powers of the Commission need to be clearly defined.

We note the proposed membership of the Commission but would request
that consideration be given in view of the onerous task of the Commission to include four medical practitioners, three of whom should be consultant psychiatrists.

The College would request that consultant psychiatrist members be nominated by the Irish Division of the Royal College of Psychiatrists which is the largest representative body of psychiatrists in Ireland.

The College strongly recommends that the Chair of the Commission, at least in the first instance, should be a consultant psychiatrist.

Mental health tribunals

Part 3, Section 47
We note that the proposed tribunal consists of two members, a medical member and a legal member. We would advise that the tribunal would be better balanced, if there were three members, the third member being a ‘lay member’.

Clinical directors

Part 6, Section 70
The College is concerned at the briefness of reference both to clinical directors and their appointment. Clarification is required as to whether clinical directors are appointed only to carry out functions as required by the mental health legislation.

The relationship of the clinical directors as defined in the Mental Health Bill and their relationship to existing resident medical superintendents and clinical directors is unclear.

The College would advise that the importance of these appointments is such that they be made by the Local Appointments Commission subject to the approval of Chief Executive Officers of Health Boards.

The College recommends that these appointments be renewable for a formal period of term of office.

Child and adolescent psychiatric services

The College has concerns about the following aspects of the proposed legislation as it relates to children and adolescents.

1. Involuntary admission
Section 24 sets out the procedures for involuntary admission of children and the circumstances in which this provision is used.

Section 24(1) does not state what examinations are necessary before an application is made to the court for the involuntary admission of a child. Neither does it state who in the Health Board can make the application to the court. It is not clear whether parents can apply for assistance in circumstances where they are willing to give consent to treatment of their child (under 18) but where the child is resisting being brought for admission.

Children must be afforded the same rights as adults. That is the right to an examination by a registered medical practitioner (in the same fashion that is available to adults) to determine whether or not they have evidence of a mental disorder which would require admission. The examining consultant psychiatrist should be the psychiatrist who works in the unit where the child will be admitted.

Section 24(2) should specify what other type of evidence may be placed before the Court. There is no reference to the role of either the clinical director or treating consultant Psychiatrist in this process.

2. Interim care and custody
Section 24(6)
Interim care and custody (between the application and the determination of an order) is at the discretion of a judge. This raises the question of whether a judge could direct that an ‘approved centre’ be used for this purpose prior to a psychiatric examination of a child. It is a worrying situation that the courts may direct an ‘approved centre’ to house a child prior to psychiatric admission. The College recommends an emergency care facility under the auspices of the Health Board, for example, children’s homes should be available.

Sections 24(7) and (8) provide for extensions of the involuntary order. Under Section 24(9) there should be an explicit requirement for a report from the treating consultant psychiatrist for this purpose (cf. renewal orders for adults).

Sections 24(12) and (13) reference the provisions of the Child Care Act 1991 which will apply to children who are subject to the involuntary admissions orders, for example, free legal aid; access to solicitors; guardian ad litem, etc.

3. Consent to treatment — children and adolescents
The most significant change proposed is that which raises the age of consent from 16 years to 18 years of age. This would appear to preclude this age group from access to mental health tribunals as provided for adults under the terms of the Bill.

Neither can this age group give consent following involuntary admission under Section 24 (see Sections 59 and 60). This appears to be a retrograde step and not in line with international trends regarding the age of consent to treatment. Under the 1998 Non-Fatal Offences Against the Person Act a 16-year-old can consent to medical treatment without parental input.

It is remiss in not allowing the views of a 16- or 17-year-old to be given in relation to consent to treatment while the anomaly exists that if they were married that they would be allowed to do so.

The concerns of the College centre around: (a) the raising of age of consent from 16 to 18 years; (b) the legal safeguards afforded to children vis-à-vis adults in relation to involuntary admission; and (c) the lack of resources.

4. Resources for child and adolescent psychiatric services
At present, resources for child and adolescent psychiatric services provide for the under 16-year-old age group. Six of the eight Health Boards have no in-patient facilities. The Eastern Health Board and Western Health Board have limited in-patient facilities in open units and these do not operate under mental health legislation. This raises the prospect of children who need involuntary admission under the Mental Health Bill 1999 only having access to adult psychiatric services.

The College would encourage development of resources for adolescent/young adult psychiatry.

Overall, the College welcomes the introduction of mental health legislation to address the needs of children and adolescents, especially in our rapidly changing and increasingly complex society. We consider it appropriate that as psychiatrists we can look forward to working under mental health legislation rather than the current situation whereby the Child Care Act 1991 is the only provision available. The introduction of separate legislation must have the benefit of distinguishing between psychiatric treatment and child care issues. The proposed legislation deals with the legalities of involuntary admission and not with the organisation or availability of services. However, the issue of resources will need to be addressed.

Resources
The College is mindful of the operating costs of the new Mental Health Commission and Inspectorate and would request that the level of resources in both financial and manpower terms be adequate.

We are also concerned about the absence of any statutory minimal standards for mental health care and treatment but are hopeful that these will be identified and published by either the Mental Health Commission and/or the Inspector of Mental Health.

Psychiatric services overall need further financial input both to raise the present standard and also to enable the Mental
Concerns and advice

1. We would advise that under the Health Board Act 1989 the terminology ‘mental handicap’ was changed to ‘intellectual disability’.

2. Informed consent

   (a) Both the adult ‘mentally handicapped’ and some elderly patients such as those with dementia are unable to give ‘informed consent’ to undergo various psychiatric and medical/surgical treatments. Many will be in ‘approved centres’ and although deemed ‘voluntary admission’ they are de facto detained as they have not the capacity to have given their informed consent.

   (b) We advise that the Mental Health Commission would have responsibility for monitoring psychiatric care and treatment of all psychiatric in-patients, (even though they are not ‘legally detained’) both voluntary and detained as the rights of voluntary and de facto-detained patients are not addressed.

   (c) The role of the Inspector of Mental Health Services should be widened to monitor all residential health centres where patients with mental disorders are receiving medical treatment without ‘informed consent’.

3. Advocacy system

   Consideration for a system of advocates, independent of the mental health services, for patients both involuntary, detained and de facto detained would be welcomed.

4. Advance directives

   Consideration might also be given to issues posed by the use of ‘advance directives’.

5. Approved centres

   The College is concerned that a number of facilities may not be suitable to be registered ‘approved’. This applies particularly to units outside the Eastern Health Board admitting children and adolescents for in-patient treatment.

6. Northern Ireland reciprocal arrangements

   The College is concerned that Paragraph 11.19 of the White Paper has not been included in the Bill. This paragraph suggested new legislation would provide the closest possible coordination of the two systems of law for the detention of those with a mental disorder and need for treatment of these patients between Northern Ireland and the Republic of Ireland. In view of the Anglo-Irish Agreement and North/South bodies perhaps this omission could be rectified.

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G. Johnston Calvert  Chairman, submitted on behalf of the Royal College of Psychiatrists Irish Division, 123 St Stephen’s Green, Dublin 2

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forthcoming events

The Professional Education & Training Unit (PET), University of Southampton are the organisers of the following conferences:

- Innovations, treatment and care, the National Association of Psychiatric Intensive Care Units Annual Conference, will be held on 31 August–1 September 2000 at King Alfred’s College, Winchester; 
- Psychosis and spirituality: exploring the new frontier will be held on 7–8 September 2000 at the Marwell Hotel, Winchester; 
- Section 12(2) Mental Health Act 1983 refresher day, a conference for Section 12(2) approved doctors, will be held on 1 November 2000 at The Royal Beach Hotel, Portsmouth; 
- Current treatments and care for sex offenders: a matter of public concern will take place on 10 November 2000 at Winchester Guildhall. Further information about all the events: Mr David K. Beck, PET Unit Director, Mental Health Group, University of Southampton, Royal South Hants Hospital, Southampton SO14 0YG (tel: 023 8082 5543; e-mail: dbkj@sooton.ac.uk; website: http://groups.medschool.soton.ac.uk/mentalhealth/).

Dr H. Birchall, Consultant Psychiatrist in Eating Disorders, Leicestershire and Rutland Healthcare NHS Trust, is the organiser of a four-day workshop on Interpersonal psychotherapy, being held on 2 October 2000 at the Leicester General Hospital. Further information: Mina Patel, George Hine House, Towers Hospital, Leicester LE5 0TD (tel: 0116 2256577).

The Institute of Health & Community Studies (IHCS), Bournemouth University, would like to announce Qualitative research in health and social care 2000, a conference taking place on 25–27 October 2000 in Bournemouth. Further information: Miss Sam Williams, Administrative Assistant, IHCS, Bournemouth University, Royal London House, Christchurch Road, Bournemouth BH1 3LT (tel: 01202 504 196).

Professor R. N. Mohan, Consultant in Old Age Psychiatry and Clinical Tutor, Northern Birmingham Mental Health NHS Trust is the organiser of a two-day management course targeted at specialist registrars in psychiatry. The course will take place on 28–29 November 2000 at the Birmingham Medical Institute. Further information: Mrs Denise Makepeace (tel: 0121 685 6574).

Manchester course for recently appointed consultants. This course will bring together 20–25 consultants appointed within the previous two years. The aim of the course is to identify problems and stresses of life as a consultant and to find ways of coping with these. The course format is interactive, with experienced consultants acting as facilitators. Main sessions are: How do I spend my time? Help — the buck stops here! The problems faced by an experienced consultant, Managing the multi-disciplinary team; and Balancing our time and our needs. The course was described enthusiastically in the Psychiatric Bulletin in 1996 (May, 20, 292–294). The course will run on 7–8 December 2000. Further information: Mrs Wendy Clarke, Secretary to Professor Francis Creed, Rannvans Building, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL (tel: 0161 276 5331; fax: 0161 273 2135; e-mail: francis.creed(at)man.ac.uk; web site: www.man.ac.uk/psych/events.html).